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ABSTRACT

The training guide begins with a rationale for the use of special education paraprofessionals working with deaf-blind and multihandicapped children in Oklahoma schools. It presents a schedule for training paraprofessional staff in 10 sessions. Resource materials are then presented as background information for the training sessions. This information covers: roles and responsibilities of paraprofessional staff, orientation to education of the handicapped, speech/language development, deaf-blind/multihandicapped curriculum, self-help/daily living skills, behavior management, motor development, physical care, and communication techniques. (JDD)

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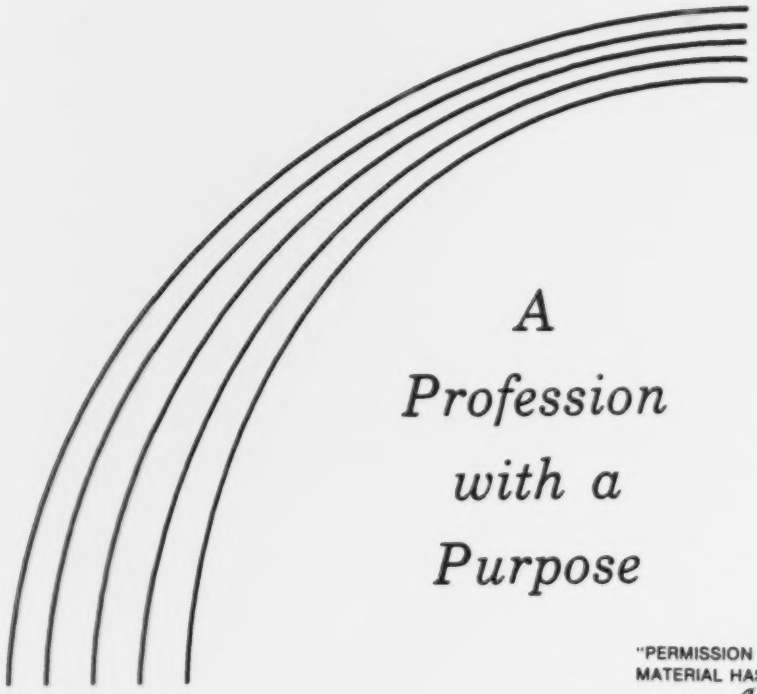
TRAINING GUIDE

SPECIAL EDUCATION PARAPROFESSIONAL



A Profession with a Purpose

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GUIDELINES FOR SPECIAL EDUCATION PARAPROFESSIONALS IN OKLAHOMA

Prepared By

The Paraprofessional Committee

of the

Special Education Section

Oklahoma State Department of Education

Oklahoma City, Oklahoma

May 1989

PARAPROFESSIONAL TRAINING

(Day 1)

8:00 a.m. -	8:30 a.m.	Registration
8:30 a.m. -	8:50 a.m.	General Session Overview/Requirements
8:50 a.m. -	9:50 a.m.	**Session 1** Roles and Responsibilities of the Paraprofessional in a Deaf-Blind or Multihandicapped Classroom
9:50 a.m. -	10:00 a.m.	BREAK
10:00 a.m. -	10:45 a.m.	**Session 2** Orientation to the Education of the Handicapped
10:45 a.m. -	11:00 a.m.	BREAK
11:00 a.m. -	12:30 p.m.	**Session 3** Speech/Language Development
12:30 p.m. -	1:30 p.m.	LUNCH
1:30 P.M. -	2:30 P.M.	**Session 4** Orientation to Deaf-Blind and Multihandicapped
2:30 p.m. -	2:40 p.m.	BREAK
2:40 p.m. -	4:10 p.m.	**Session 5** Deaf-Blind and Multihandicapped Curriculum
4:10 p.m. -	4:20 p.m.	BREAK
4:20 p.m. -	5:30 p.m.	**Session 6** Self-Help/Daily Living Skills

PARAPROFESSIONAL TRAINING

(Day 2)

8:00 a.m. -	9:00 a.m.	**Session 7** Behavior Management
9:00 a.m. -	9:15 a.m.	BREAK
9:15 a.m. -	10:15 a.m.	Behavior Management (continued)
10:15 a.m. -	10:30 a.m.	BREAK
10:30 a.m. -	12:30 a.m.	**Session 8** Motor Development of Deaf-Blind and Multihandicapped Children
12:30 a.m. -	1:30 p.m.	LUNCH
1:30 p.m. -	2:30 p.m.	**Session 9** Physical Care of Deaf-Blind and Multihandicapped Children
2:30 p.m. -	2:45 p.m.	BREAK
2:45 p.m. -	3:45 p.m.	Physical Care of Deaf-Blind and Multihandicapped Children (Continued.)
3:45 p.m. -	4:00 p.m.	BREAK
4:00 p.m. -	5:15 p.m.	**Session 10** Communication and the Paraprofessional
5:15 p.m. -	5:30 p.m.	Closing of Training
		Certificates of Completion
		Register
		Travel Claims

PARAPROFESSIONAL TRAINING

OVERVIEW

I. The Special Education Paraprofessional Option

A. Background and Need

B. Classroom Aids and Paraprofessionals

C. District Level Participation

II. Training

A. Schedule

B. Format of Training Sessions

C. Training Materials

D. Orientation to Site

III. Requirements

Successful completion for entry in the Special Education Paraprofessional Register maintained by the Oklahoma State Department of Education will be based upon:

A. Attendance

B. Participation

C. Inservice

SPECIAL EDUCATION PARAPROFESSIONALS

INTRODUCTORY STATEMENT

The number of severe-profoundly handicapped children receiving educational services in public schools in Oklahoma is steadily growing. Local schools are providing programming for these children due to the mandates of state and federal legislation. More and more severe-profoundly handicapped children who were in institutional settings or receiving no educational services are being served in public school programs. Research has shown the use of paraprofessionals with severe-profoundly handicapped children as educationally advantageous. The paraprofessional program has improved services to handicapped children and assisted schools in the complex endeavor of providing a free, appropriate public education to severe-profoundly handicapped children.

LEGAL AUTHORITY AND DEFINITION

The Administrators' Handbook for Elementary, Middle, Junior High and High Schools, July 1987-88, Appendix H Special Education, Program Option/Multihandicapped and Deaf-Blind states:

> "The State Board of Education, pursuant to (70-13-105), deems it necessary to authorize the use of a trained paraprofessional in the teaching of handicapped children categorized multihandicapped and deaf-blind.
>
> The State Board of Education defines a trained paraprofessional as a person listed on the paraprofessional register maintained in the Special Education Section of the State Department of Education. These persons will have completed paraprofessional training administered by the State Department of Education. Unless prohibited by statute, the trained paraprofessional my conduct activities of the components of the Individualized Education Program of multihandicapped or deaf-blind children. The trained paraprofessional will conduct these activities under the direction of a certified special education teacher."

The special education paraprofessional works alongside the special education teacher. With differentiated responsibilities, the paraprofessional carries out the program developed by the special education teacher for multihandicapped or deaf-blind children.

Subsequent to Appendix H of the 1987-88 Administrators' Handbook, policies for training, utilization, supervision and application procedures for special education paraprofessionals have been established to ensure proper implementations of this program option.

CLASSROOM TEACHER AIDES

The definition of special education paraprofessionals, stated in Appendix H, does not include those individuals who are referred to as classroom teacher aides in Section VII of the Administrators' Handbook.

UTILIZATION OF PARAPROFESSIONALS

The role of the certified special education teacher includes the diagnosis of educational needs of handicapped children and the subsequent planning and implementation of programs and procedures which meet the educational needs of individual handicapped children. Instruction involving the presentation of new concepts is the responsibility of the certified teacher.

The role of the paraprofessional is to provide support to the multihandicapped (MH) certified special education teacher in the delivery of services to multihandicapped and deaf-blind children. The

direction provided to paraprofessionals by certified personnel is the foundation of a successful program which utilizes the paraprofessional program option.

DUTIES AND RESPONSIBILITIES

Generally, the paraprofessional will be involved in three areas: conducting activities which reinforce IEP objectives, student management, and required noninstructional duties.

It is essential for the MH certified teacher to recognize the skill level possessed by the paraprofessional entering the multihandicapped or deaf-blind setting. The paraprofessional will need specific direction in performing activities typically found in the multihandicapped or deaf-blind classroom including self-help skills, communication skills, cognitive skills, pre-academics/academics, motor programming such as positioning and handling, behavior management and any adaptive equipment utilized by individual handicapped students. Hygiene is of utmost importance in multihandicapped and deaf-blind classroom maintenance. The certified teacher and paraprofessional will need to communicate extensively with regard to activities required to ensure the hygiene of materials, equipment, clothing and the classroom.

ADMINISTRATIVE PROCEDURES

No more than three paraprofessionals, whether full-time or part-time, shall be assigned to a MH certified teacher. No paraprofessional shall be assigned to more than two MH certified teachers or educational facilities. Paraprofessionals may work with individual students, small groups, or the total classroom. The student-teacher ratio for multihandicapped, deaf-blind classrooms will remain the same.

SUPERVISION OF STUDENTS

Paraprofessionals may work with or supervise students in the classroom, playground,hall, restroom, therapy area, gymnasium,other specified areas on a school campus, community-based activities, and transportation situations. In some situations the paraprofessional may conduct this supervision without the MH certified teacher being present. When supervising students without the MH certified teacher being present, the paraprofessional should have designated certified personnel to report to for direction and consultation.

FISCAL POLICIES

For school year 89-90, a local education may apply for EHA-B discretionary funding of paraprofessionals. Paraprofessionals will be employed for the EHA-B discretionary application period. Applicants are subject to requirements and priorities as outlined in the EHA-B Policies and Procedures Manual, page 6.

The paraprofessional shall be counted as full-time if employed six or more hours per day,or half-time if employed a minimum of three hours per day.

JOB DESCRIPTIONS

Paraprofessionals should have job descriptions which clearly define the duties and responsibilities they will perform in the multihandicapped or deaf-blind program to which they will be assigned. The job description will be submitted with the discretionary application. The job description should parallel other noncertified positions in the district.

TRAINING

A register of trained paraprofessionals will be maintained by the OSDE, Special Education Section. To qualify for this register, a person must satisfactorily complete an initial twenty hours of training conducted by the OSDE. Following satisfactory completion of the initial training, a paraprofessional will complete an additional six hours of training each school year. This annual training could be coordinated as part of the local school's staff development plan and supported through C.S.P.D. The LEA making application for reimbursement of a paraprofessional's salary will be responsible for submitting a training proposal with the EHA-B discretionary application. The six hours annual LEA training provided the paraprofessional will be specific to the multihandicapped or deaf-blind program to which the paraprofessional is assigned.

SUPERVISION AND EVALUATION

Special education paraprofessionals shall be directly supervised by the MH certified special education personnel to whom they are assigned. Overall supervisory and evaluative responsibilities rest with the school administrator as they do for other school staff members.

TRAINING SESSION INFORMATION

Session 1: ROLES AND RESPONSIBILITIES

(Resource Section, pp. 25 - 36)

I. The Role of the Special Education Paraprofessional

The role of the paraprofessional is to provide support to the Multihandicapped certified teacher in the delivery of services to children.

"Para" is defined as "by the side or, beside, alongside of, . . .". Thus, the title itself sets out the role of this person as one working alongside a certified teacher.

II. Responsibilities of the Special Education Paraprofessional

A. Activities which reinforce IEP objectives

1. Communication Skills
2. Cognitive Skills
3. Motor Programming

B. Student Management

1. Behavior
2. Physical Care
3. Daily Routine of Self-help Skills

C. Noninstructional Duties

1. Materials and Equipment - Maintenance and Preparation
2. Field Trips
3. Transportation

III. Clarification of Role

A. Responsibility for understanding of position description

B. Responsibility for clarifying duties

1. Job Description - District Level
2. Building Administrator
3. Multihandicapped Certified Teacher

PARAPROFESSIONAL TRAINING

Session 2: ORIENTATION TO EDUCATION OF THE HANDICAPPED
(Resource Section, pp. 37 - 60)

I. Federal Regulations

A. Historical Perspective of P.L. 94-142

1. Brown v. Topeka

2. Section 504

3. Passage of P. L. 94-142 in 1975; Implementation - 1977

B. Overview of the Education for All Handicapped Children Act, also referred to as EHA and P.L. 94-142

1. Free Appropriate Public Education - FAPE

2. Least Restrictive Environment - LRE

3. Rights

4. Due Process

5. Funding

6. Categories of Handicapping Conditions

II. State Regulations

A. Historical Perspective of Special Education in Oklahoma

B. Implications of P. L. 94-142 for Special Education in Oklahoma

1. State Plan

2. Policies and Procedures

C. Delivery Systems

D. Regulations specific to Oklahoma

1. Class Size

2. Categories

3. Individualized Education Program (IEP) and Teams.

E. Funding

Session 2: ORIENTATION TO EDUCATION OF THE HANDICAPPED (Continued)

III. Procedural Safeguards

A. Step-by-Step Provision of Special Education Services

B. Documentation of Procedural Safeguards

C. Confidentiality - Confidential Folder

D. Due Process System

Session 3: SPEECH / LANGUAGE DEVELOPMENT
(Resource Section, pp. 61 - 63)

Introduction:

Meet David:

Meet Tina:

I. Communication /Language /Speech

A. Definitions - illustrations

1. Communication -

- to impart or make known - to communicate information
- to give to another; transmit, ie. to communicate a disease or an idea.
- commune - an interchange of thoughts or feelings

Our goal is to enable children to take part in communication.

2. Language - Levels of functioning

a. inner language - cognitive ability - the act or process of knowing or perceiving.

example: aware that a doll is to hold and cuddle

b. receptive language - Language that is spoken or written by others and received and understood by the individual.

Normal - language is normally received by listening and reading.

Problem Possibilities:

- hearing and/or vision impairment
- auditory or vision processing dysfunction
- motor limitations
- mental limitations
- emotional disorders

Deaf/Blind-Mulithandicapped

Multi-sensory approach:

hearing, seeing, touching, smelling, tasting

c. Expressive language - skills required to produce language for communication with other individuals.

Normal: Language is normally expressed by speaking or writing.

Verbal communication requires:

- cognition - knowing a concept
- semantics - choosing appropriate words
- syntax - word order
- grammar - word formation
- articulation - sound usage
- pragmatics - socially appropriate usage

Deaf/Blind - Multihandicapped

Verbal - with limitation

Gestural - signing, pointing

Graphic - writing, typing, micro-computer

Total communication

B. Requirements for Communication

1. Sender - Receiver
2. Basic Abilities
   a. Social
   b. Mental
   c. Physical

C. Alternative Methods of Communication

1. Auditory-Verbal
2. Manual-Gestural
3. Visual-Graphic
4. Combinations

II. Describe Three Communication Needs of the Deaf/Blind-Multihandicapped Population

A. Educational:

1. Facilitate success
2. Facilitate learning strategies
3. Facilitate skill mastery

B. Psycho-Social:

1. Communication frustration
2. Expression of feelings
3. Disability vs. handicap

C. Environmental -

1. Expression of needs
2. Self-care needs

III. Describe Three Major Roles of the Paraprofessional in the Development of Communication Skills in the Deaf-Blind and Multihandicapped Population.

A. Motivation

B. Repetition

C. Discipline - refer to reference Section pp. 61 - 63.

Session 4: ORIENTATION TO / DEAF-BLIND MULTIHANDICAPPED
(Resource Section pp. 64 - 86)

I. Orientation

A. Brief Overview of Multihandicapped and/or Deaf-Blind Conditions

1. Genetic Disorders
2. Physical Disabilities
   a. Pre-Natal Causation
   b. Post-Natal Causation

B. Understanding Terminology and Characteristics

1. Physical Characteristics
2. Developmental Characteristics

C. Dealing with Parents

1. Understanding Attitudes
2. Para-Professional's Role

D. Feedback from Para-Professional's

Session 5: DEAF-BLIND/MULTIHANDICAPPED CURRICULUM
(Resource Section, pp. 87 - 94)

I. Basic Curriculum

A. Pre-Academic/Academic skills

B. Daily Living/Self Help skills

C. Social skills

D. Motor skills

E. Perceptual skills

F. Communication skills

G. Leisure skills

H. Attending skills

I. Transition skills

J. Pre-Vocational skills

K. Vocational skills

L. Community Based skills

II. Teaching curriculum

A. How does the student best learn

B. Sequence to be taught

C. Functional curriculum,

D. Age appropriate activities

E. Least restrictive environment

III. Paraprofessional's Responsibilities

A. Curriculum

B. Selected Activities

1. Free play, Games, Leisure Skills

2. Pre-Academic/Academic Skills

3. Language/Communication

4. Toileting/Personal Hygiene

5. Feeding/Eating
6. Art
7. Music
8. Cooking
9. Outdoor Play/Physical Education
10. Jobs in the Room
11. Opening Exercises (Primary)
12. Rest Time (Primary)

C. Summary

IV. Feedback from Paraprofessionals

A. Description of One Activity

B. Description of Appropriate Teacher Paraprofessional Activity

Session 6: SELF HELP / DAILY LIVING SKILLS
(Resource Section, pp. 95 - 99)

I. Long Term Goals

II. Short Term Goals

A. Daily Living/Self Help Skills

1. Feeding/Eating

a. Task Analysis

b. Examples

2. Dressing

a. Prompting

b. Shaping

c. Chaining

d. Examples

3. Toileting

4. Other Daily Living/Self Help Areas

a. Partial Participation

b. Examples

B. Paraprofessional's Role

C. Task Analysis - Examples

D. Small Group Activity - Short Term Goal Task Analyzed by Paraprofessionals

Session 7: **BEHAVIOR MANAGEMENT**
(Resource Section, pp. 112 - 115)

I. Increasing Positive Behaviors

A. Define "Positive"

B. Examples
1. Attending Behavior
2. On-task Behavior
3. Following Commands

II. Decreasing Negative Behaviors

A. Define "Negative"

B. Examples
1. Distractibility
2. Resistive Behavior
3. Self-stimulation Behavior
4. Tactile defensiveness

III. Motivation

A. Theirs

B. Yours

IV. Basic Elements of Behavior Management

A. Consequences
1. Types of Consequences
2. Effects of Consequences
3. Reinforcement

B. Structuring

C. Shaping

D. Insight Behavior

V. Possible Responses to Situations

A. Distractibility

B. Resistance

C. Other

VI. A System for Classroom Behavior Management

A. Identify Goals (Yours and the Child's)

B. Identify Usable Consequences

C. Consistent Application of Consequences

D. Persistent Application

"CATCH THEM DOING SOMETHING GOOD BEFORE THEY DO SOMETHING BAD."

Session 8: MOTOR DEVELOPMENT OF DEAF-BLIND OR MULTIHANDICAPPED CHILDREN (Resource Section, pp. 116 - 130)

I. Overview of PT - OT

A. Common Deficits Addressed in a Multihandicapped or Deaf-Blind Classroom

1. Cerebral Palsy, Spina Bifida, Muscular Dystrophy, etc.

B. Common PT - OT Techniques

1. Positioning,Handling, Feeding

II. Paraprofessional Interaction with a PT - OT

A. Communication Between PT - OT and Classroom Personnel

B. Legal Implications

C. Implementation of PT - OT IEP Objectives or Therapy Plans by the Paraprofessional

D. When to Ask Questions Concerning PT - OT Activities

III. PT - OT Equipment

A. Overview of Common Equipment/Devices

B. Uses of PT - OT Equipment/Devices

Session 9: PHYSICAL CARE OF DEAF-BLIND OR MULTIHANDICAPPED CHILDREN
(Resource Section, pp. 131 - 155)

I. Hygiene and Communicable Diseases

A. How Communicable Diseases are Transmitted

B. Methods of Disinfecting Materials, Equipment, Clothing

II. Administration of Medication

A. Consultation with Supervising Teacher

B. Considerations and Procedures for Administering Medication

1. District Procedures
2. Permission / Release Forms Signed by Parents
3. Proper Storage
4. Recording Administrations
5. Directions for Administering

III. Orientation to First Aid Procedures

A. What to do in Emergency Situations

1. Choking
2. Bleeding
3. Injuries to Head and Neck
4. Seizures
5. Fainting
6. Asthmatic Reactions, Burns

Session 10: COMMUNICATION AND THE PARAPROFESSIONAL
(Resource Section, pp. 100 - 111)

I. Define "Communication"

II. Listening Skills

- A. Active
- B. Passive

III. Communication Skills

- A. Assertion
- B. Self Disclosure
- C. "I" Messages
- D. Inquiry
- E. Fogging
- F. Broken Record
- G. Self-Conversation
- H. Wants verses Needs

IV. Roadblocks to Communication

RESOURCES

Special Education Paraprofessional

This guide contains information helpful to the special education paraprofessional. It is divided into areas addressed by each outline. These are the areas in which the paraprofessional will function and interact with deaf-blind or multihandicapped children. The selections represent a beginning of information gathering in these area. Hopefully, through the special education paraprofessional's experiences and subsequent training, additional resources and information will be collected.

ROLES AND RESPONSIBILITIES OF THE PARAPROFESSIONAL IN A DEAF-BLIND OR MULTIHANDICAPPED CLASSROOM

Job Description

Paraprofessionals

SPECIAL EDUCATION PROGRAMS

The purpose of an educational program for special education students is to provide opportunities for optimum physical, social emotional and cognitive growth. The goal is to help the students develop, strengthen, and/or maintain self care, physical, social, communication and intellectual skills. Paraprofessionals are employed to assist in providing the program designed to meet the specific goals and objectives for each student. Assist means to aid or perform duties assigned by the principal and other certified/licensed persons in charge of the program.

The productive efficient paraprofessional is an instructional partner, a helper, a supportive adult during crisis situation, a guide for substitutes and a positive model for students.

The duties of a paraprofessional may include, but not be limited to the following:

1. Instruction and Supervision
    a. Monitor student(s) during classroom and playground activities.
    b. Assist with instruction and/or activities for individuals or groups.
    c. Prepare materials, set up equipment.
    d. Maintain records for evaluation of students' behavior and performance.
    e. Obtain food from cafeteria, return trays.
2. Physical Needs and Training
    a. Change diapers, sanitary napkins, clothing.
    b. Assist in toilet training.
    c. Aid in feeding and teaching eating skills.
    d. Assist with personal care, wiping nose, drool, hand washing, body care.
    e. Help develop dressing skills.
    f. Position and aid students to move from wheelchair, desk, walker and etc.
3. Room Maintenance/Housekeeping
    a. Clean room and equipment after instructional activities and feeding.

b. Prepare room (material, equipment) at close of school in readiness for the next day.

c. Launder towels, clothing and cleaning materials.

4. Transportation

a. Help load and unload buses.

b. Assist students to and from classes and services, bathroom, cafeteria, etc.

c. Accompany or assist students during off campus activities.

5. Professionalism

a. Adhere to negotiated agreement and school schedules (working hours, breaks, lunch and absenteeism).

b. Maintain confidentiality (student[s] records and discussions).

c. Practice aseptic techniques and cleanliness.

d. Utilize care of equipment and materials.

SPECIAL EDUCATION

POSITION TITLE: Paraprofessional

GRADE LEVEL:

Introduction - (purpose of the position):

The purpose of an educational program for Special Education students is to provide opportunities for optimum physical, social, emotional and cognitive growth. The goal is to help the students develop, strengthen, and/or maintain self care, physical, social, communication and intellectual skills. Paraprofessionals are employed to assist in providing the program designed to meet the specific goals and objectives for each student. Assist means to aid or perform duties assigned by the principal and other certified/licensed persons in charge of the program.

The productive efficient paraprofessional is an instructional partner, a helper, a supportive adult during crisis situation, a guide for substitutes and a positive model for students.

1. **Knowledge Required**:

   Cognitive level necessary to: 1) assess situations and make appropriate judgements, 2) communicate effectively, 3) interpret and follow directions, 4) perform basic academic skills, 5) assume the responsibility of the assignment.

2. **Supervisory Controls**:

   A paraprofessional is employed by and works for the Local Education Agency and is assigned to a school to perform duties designated by the principal and/or other certified/licensed persons. The assignment of each paraprofessional will vary depending upon the needs of the students. Although paraprofessionals work under the supervision of a certified staff member, each must assume the responsibility for working independently while following directions. The principal is responsible for formal evaluation.

3. **Guidelines**:

   Interpretation of guidelines must be made depending on the specific assignment. Duties will vary and may include but not be limited to the following:

   1) Instruction and Supervision

   a. monitor student(s) during classroom and playground activities.
   b. assist with instruction and/or activities for individuals or groups.
   c. prepare materials, set up equipment.
   d. maintain records for evaluation of students' behavior and performance.
   e. obtain food from cafeteria, return trays.

   2) Physical Needs and Training

      a. change diapers, sanitary napkins, clothing.
      b. assist in toilet training.
      c. aid in feeding and teaching eating skills.

3. Guidelines: - 2) Physical Needs and Training (Continued)

   d. assist with personal care, wiping nose, drool, hand washing, body care.
   e. help develop dressing skills.
   f. position and aid students to move from wheelchair, desk, walker, etc.

   3) Room Maintenance/Housekeeping

   a. clean room and equipment after instructional activities and feeding.
   b. prepare room (material, equipment) at close of school in readiness for next day.
   c. launder towels, clothing and cleaning materials.

   4) Transportation

   a. help load and unload buses.
   b. assist students to and from classes and services, bathroom, cafeteria, etc.
   c. accompany or assist students during off-campus activities.

   5) Professionalism

   a. adhere to negotiated agreement and school schedules (working hours, breaks, lunch and absenteeism).
   b. maintain confidentiality (student[s] records and discussions).
   c. practice aseptic techniques and cleanliness.
   d. utilize care of equipment and materials.

4. **Complexity**:

   Activities are often routine and repetitive in nature, however the various duties involved in care for and instructing students require the paraprofessional to make responsible judgements.

5. **Scope and Effect**:

   A paraprofessional is assigned to assist the teacher (or other certified personnel) in the care and instruction of the students. When a paraprofessional does not perform the job well, the student(s) will not benefit from the program as planned. Often minor disruptions or areas of neglect will result in major educational or physical problems for the student and will effect the school and often the entire school district.

6. **Personal Contacts**:

   A paraprofessional is part of the building staff and will participate with other staff members in activities and duties as designated by the principal, teacher or other certified/licensed person in charge of the program. The duties will involve contact with school personnel, students, parents, volunteers and other professional groups (such as student teachers and interns).

7. **Purpose of Contacts**:

   The purpose of contacts will be to: 1) assist in the care and instruction of students, 2) assist and communicate with parents and others in a friendly, professional and caring manner concerning program and student activities.

Purpose of Contacts: (Continued)

8. **Physical Demands**:

The responsibility of a special education paraprofessional varies according to the particular needs of the student(s). Some duties will require lifting and assisting students with limited self-help skills. Other duties will require a paraprofessional to work with patience, consistency and endurance as the task is performed.

9. **Work Environments**:

The classroom (or approved area -field trip,etc.) and adjacent care facility are the usual work area.. Care has been taken to provide aseptic conditions for programs serving students with limited self-help skills. Paraprofessionals are required to follow the procedures outline for health care and safety.

10. **Other Significant Facts**:

A paraprofessional will: 1) be aware of the job responsibilities and related activities, show initiative and be willing to perform duties without having to be requested or directed, 2) be required to act in a professional manner and maintain confidentiality.

CHECKLIST FOR YOU TO FIND OUT

1. What are your special and regular duties?
2. What records are you responsible for keeping?
3. What special services are available to the classroom and the school in which you work?
4. What schedules are you responsible for following?
5. What emergency provisions apply to your situations?
6. When do pupils come? When do they leave?
7. Where and when will the pupils in your classroom play?
8. What are the most significant playgound regulations?
9. For what lunch time activities will you be responsible?
10. Where are the supplies kept and how are they obtained?
11. What equipment is available and how is it obtained?
12. What is the line of communication and authority you are to follow?
13. If you are responsible for working with more than one teacher, how is your time divided?
14. What pupil records are available to you?
15. To whom should you direct questions concerning school policy?
16. With whom should you discuss a problem concerning relationships?
17. What should your response be when a parent raises question on their child's functioning in the classroom?
18. What is expected of you in terms of pupil management?
19. What course should you follow if you feel that you do not have enough to do?
20. How does your teacher view the teacher/paraprofessional relationship?

DUTIES OUTSIDE THE CLASSROOM

Lunch Duty

It may be a part of your duties to take students to lunch, supervise them at lunch, eat with them, or supervise the lunch line. You may have to go after lunches in some cases. If you supervise students, they should follow the same rules in the lunchroom which other students follow. Stress good table manners and courtesy.

Check with your teacher about your lunch responsibilities and eating arrangements.

Recess Duty

You may be responsible for supervising students on the playground. If so follow the rules of the playground.

Do not hesitate to reprimand other students on the playground if they are not obeying rules or engaging in an activity dangerous to themselves or others.

Find out from your teacher what punishments are appropriate for playground behavior.

Bus Duty

You my be responsible for seeing that students get on the right buses at dismissal and you may need to supervise them while they are waiting.

Be sure you know the correct buses for each student and the usual time of arrival of the buses. Have students ready to board the buses.

If you are on bus duty, you are solely responsible for the behavior and correct boarding of buses by the bus students.

Mainstreaming

If a student is mainstreamed in the regular class for an hour or two you may be required to assist that student and the regular teacher within the regular classroom. Talk with the regular classroom teacher on what is expected of you in working with the student.

Physical Therapy

You may be required to assist the physical therapist in working with the student during P.T. Consult with the physical therapist in what you are to do. Be a helping hand, not a hindrance.

Field Trip Responsibilities

Your teacher will tell you what responsibilities she expects from you on field trips. In general, she will expect you to supervise activities and keep track of students. Expect students to behave as they would normally for you. Modify your expectations to the situations.

REMEMBER:

Know what is expected of you and what your responsibilities are. Get all aspects clarified.

SUGGESTIONS FOR BECOMING A MORE SUCCESSFUL PARAPROFESSIONAL

1. Learn the names of pupils immediately.
2. Learn as much about each child as quickly as possible.
3. Lend personal assistance to pupils wherever possible.
4. Consult often with the teacher as to how you can help.
5. Give encouragement to pupils whenever and wherever you can.
6. Praise pupils' efforts and successes.
7. Be patient in dealing with pupils.
8. Become familiar with the school building, grounds, personnel.
9. Learn the routine of the school day.
10. Get acquainted immediately with emergency procedures.
11. Learn the location and how to use the equipment.
12. Get acquainted with school policy as it applies to you and your work.
13. Inform the teachers with whom you work of any special talents, interests, or special experiences you have had.
14. Practice observing in a meaningful way every chance that you get.
15. Watch carefully how the teacher deals with and directs pupils.
16. Exchange telephone numbers with your teacher(s)
17. Get acquainted with other staff members.
18. Be mature in your conduct and demonstrate that you are a responsible person.
19. Ask for clarification when you do not understand an assignment or suggestion.
10. Be on time and leave at an appropriate time.

BEING A "PROFESSIONAL PARAPROFESSIONAL"

1. Be on time to work. The teacher and students depend on you.

2. Be a responsible person. Don't force the teacher to always plan tasks for you. Work with the teacher, not against him/her.

3. Always conduct yourself as a paraprofessional, i.e., to manners, attitude, and appearance. Remember you are representing yourself and the school district.

4. Be accurate in your work. Get work done on time.

5. Listen to directions and follow them. If unclear, ask questions. Never resort to your own methods unless discussed with the teacher first.

6. Work only on teaching concepts the teacher has set for the student. If unclear, ask questions.

7. Perform tasks before you have to be told. Know what has to be done. Don't rely on the teacher to always have to tell you.

8. Spend time before school or after school learning where materials and equipment are within the classroom and building. Always return materials and equipment where they belong. Don't make the teacher hunt or have to ask you where it is.

9. Let teachers know when the task is done, then proceed to another task.

10. Become eager to assist the teacher both in clerical and in instructional tasks. Don't sit back and watch. Be an instructional paraprofessional.

11. Don't feel that you should begin or leave your job at the exact starting and stopping times. Come a few minutes early and stay a few minutes later. This gives you the opportunity to visit with your teacher on the events of the day and how the day went. This is all in being part of a professional team. A little extra of your own time lets people know that you are proud of what you do and interested in your job and doing the best you can do to help the instructional process of the students.

12. Establish a working relationship with the teacher and the students.

13. If a paraprofessional smokes, he/she may have to do without during the hours he/she works, for the teacher's lounge is no place to smoke, nor the restrooms or any other place within the building or school grounds. You must respect the feelings of the other faculty members.

14. If you take your job seriously and are always trying to do a better job to become a good paraprofessional, then being a paraprofessional is hard work. If you can't dedicate yourself to this, then you may be in the wrong profession. Make sure, for the program depends on this. <u>Being a professional paraprofessional takes hard work and dedication</u>.

15. Be polite and considerate of the students' needs. Show them you care and are interested in them by assisting them in any way you can. Don't assist a student in a task, whether it be in the class, recess, or lunch room, then walk off and forget the student. Show the students you are there to assist them if they should need any more help.

16. Learn the procedures of the school in regard to recess, restrooms, lunch, classrooms, drinks, and going from building to building.

17. Never show your disapproval in a task assigned to you in front of the student or students. Go ahead and perform the task or teaching concept, then discuss it with the teacher after school.

18. Perform duties assigned to you by teachers and principals. If you feel you should not perform the duties, then discuss it with them after school, or refer it to the special education office.

19. Make yourself aware of the students' needs and limitations.

20. Remember confidentiality in relation to students and all school matters.

22. Get to know the staff members in the building. It will help with the communication factor of the student. Don't remain a stranger.

23. In general, cooperate,communicate, anticipate tasks and teachers' needs within the classroom. Take your job seriously. Become interested and involved in the instructional process of the student. Learn from the teacher.

24. Learn from your mistakes. Correct your mistakes. Always strive to improve your job performance. Take pride in your job and the duties you perform.

DISPLAY DEDICATION AND PROFESSIONALISM TAKE PRIDE IN WHAT YOU DO AND OTHERS WILL BE PROUD TO HAVE YOU A PART OF THEIR TEAM.

A DAY IN THE LIFE OF A PARA

Your day would begin with opening exercises. This would be the same procedure each day:

The children are greeted, each sings a song about themselves. 1. Good Morning, or 2. I Have a Friend

Role is taken. This helps with name recognition.

Rhymes - The songs should be appropriate to age.

Units are discussed - A simple unit is appropriate. Real objects are recommended for lower functioning children. Before you move onto pictures or ideas you must have a foundation.

An example of a unit would be toys, food, people, etc.

Functional behaviors stressed should be: follow directions, take part in own way, and sit at table.

Paras role would be to sit at the table or behind a certain child and prompt physically at times if needed and assist physically at times but do not divert children by talking. The para gets props and removes them. The para supports but does not divert from the teacher. If the teacher is called away or must remove a child the para can step in and keep the lesson going without interruption.

The para's responsibility in the classroom is to help direct the children, keep them in the room, see what the teacher misses, and watch for safety.

During game time paras are active participants in maintaining circle or keeping ball going. In musical chairs, physically help the children around.

During center time the para fills in as teacher on curriculum that the teacher sets up. Record keeping will be done by both the teacher and para. Model your teacher and use your own ideas (with her acceptance). Functional teaching is important, make a selection and stay with the task giving simple choices. Older children should have responsibility to get and return their own materials. Younger children do as much as possible.

LANGUAGE: Be a good model of appropriate speech. Try to illicit speech. Wait for a response rather than quickly providing it. Some suggestions to develop receptive and expressive language are: 1. Utilizing music, 2. Physical activity to develop concepts through movement and music. 3. Units of categories to name and label things. 4. Parroting what the child has said in appropriate speech. 6. Taking advantage of daily situations to talk to the child and tell him what he is doing and what is happening. 7. Books/Pictures.

TOILETING SKILLS. Many concepts can be taught in the bathroom. This is a place to teach not only body hygiene and cleanliness but also body parts, sequential directions, independence. Don't do for the child-let him try first then talk and show him what is expected. Toileting skills include combing hair, brushing teeth, washing hands and face, using the toilet then cleaning self, etc. There are several methods for toilet training. Use the one your teacher recommends and use clorox/water disinfectant spray (on surfaces-never on child). *1 tbs. chlorox to 1 gallon water - spray; then air dry-rinse surface later.

EATING/FEEDING: This is a most important teaching time. Older children can serve and clean up with training for future food service jobs. The younger children can assist in passing out napkins, etc. Set rules for acceptable behavior and maintain them. The child should communicate eating

needs and wants - food is a fantastic motivator and language can be illicited by its use. The goal is self-feeding in an appropriate way. If the child is profoundly handicapped (CP) the feeding technique developed by the OT and teacher should be followed.

REST TIME: This is the time to take out mats/cots, and maintain a restful room. Take out books - good time to help develop leisure skills. Also quiet music can help the children relax. It is important to know each child's schedule of sleeping time. Usually a good rule of thumb is to let the child sleep for 40 minutes and no longer. Sleeping longer can disrupt his nighttime sleeping routine, cause problems for the parents, and start vicious cycle of sleeping problems. Especially the blind child - sleeping can definitely become a problem.

OUTDOOR PLAY: Here is time when large muscle movement is encouraged. Activities and programs set up through adaptive P.E. are followed through here. Watch out for safety procedures.

ART ACTIVITIES: In group activities, preparation of materials is important to do ahead of time. Check the surplus of materials. Check on the proper sequence with teacher and help only when needed to have a successful end product.

COOKING ACTIVITIES: this is an excellent way for more able children to learn math and basic reading. Para's can prepare the supplies, the children make and clean up. This activity rewards itself.

SUMMARY

1. All activities are structured.
2. Top down approach; show the whole first
3. Always keep in mind how we function in this environment is important. We learn how to get along here so we can function well in society and be accepted.
4. We model appropriate behaviors, use good manners, reinforce good behaviors, ignore acting out when possible, follow the teachers directions by communicating daily.
5. Help the teacher keep records.
6. Give insightful feedback - what works and what doesn't.
7. The goal is whatever degree of maximum self-sufficiency is possible

ORIENTATION TO THE EDUCATION OF THE HANDICAPPED

2. The local education agency is responsible for all exceptional children who are legal residents of the district. Independent school districts are responsible for ages 0-21. Dependent schools have the responsibility for ages 0 through the grade level of the school. (Example: school has classes to sixth, seventh, or eighth grade.) Upon leaving the dependent school, the responsibility for the educational program for a handicapped student is assumed by the independent district receiving the child (the same as nonhandicapped student) if the dependent school is in the independent school's transportation area. If the child is transferred outside the transportation area, the dependent school retains responsibility for special services.

3. A local education agency may fulfill these responsibilities by:

   a. District directly providing special education for such children;

   b. District joining in a cooperative program with another district or districts to provide special education for such children;

   c. District joining in a cooperative program with a private or public institution within such district to provide special education for children who are deaf or hard-of-hearing, or for children who are blind or partially blind; or

   d. Transferring certified exceptional children to other school districts which accept them and provide special education for such children, with the district in which the child resides paying tuition therefore as hereinafter provided. (70-13-101)

4. Given the department of education philosophy that special education is an integral part of regular education, all service delivery systems must offer the following possible placements ranging from the least restrictive (maximum opportunity for contact with nonhandicapped children) to the most restrictive (least contact with nonhandicapped children).

   a. Regular classes

   b. Special classes

      (1) Resource lab

      (2) Self-contained

   c. Special separate schools

   d. Home instruction

   e. Institutions/hospitals

PROGRAMS OR CLASSES

CLASS TYPE	EVALUATION	ELIGIBILITY STANDARDS*	SELF-CONTAINED MAXIMUM CLASS SIZE **	AGE***
Blind and Visually Impaired	Ophthalmological Educational	Corrected visual acuity of 20/70 or less, or visual field no greater than 20 degrees in the better eye, or a visual impairment which, even with the best correction, adversely affects performance in a regular class	10	0-21
Deaf-Blind	Audiological Ophthalmological Educational	Functional impairment in both hearing and vision so severe that they cannot be served in classes solely for deaf or blind	10	0-21
Deaf/Hard-of-Hearing	Individual Audiological Educational	40 minimum decibel loss or hearing impairment which even with best correction adversely affects performance in a regular class	15	0-21
Multihandicapped	Psychological Developmental Educational Medical	Two or more impairments so severe that they cannot be served in programs solely for one of the impairments	10	0-21
Mentally Retarded --- Educable --- Trainable	Psychological Educational Developmental Adaptive Behavior	Deficits in I.Q. and adaptive behavior functioning --- I.Q. 50-75 --- I.Q. 30-50	 --- 15 --- 10	 --- 4-21 --- 0-21
Orthopedically Impaired (Physically Handicapped)	Medical Psychological Educational	Physically handicapped to the extent of needing special education	15	0-21

* Following the law, all eligibility placement will be done by a team. Individual needs and appropriateness must be considered.

** Class size is based on a full-time special teacher. Less than full-time, the class size will be prorated. Example: a half-time lab teacher could serve 13 students. **NOTE: See page 8 for laboratory or resource room sizes.**

*** Severely handicapped children may begin receiving special education services at birth. These children are operationally defined as those functioning 50% or more below normal expectancy for their age.

PROGRAMS OR CLASSES

CLASS TYPE	EVALUATION	ELIGIBILITY STANDARDS*	SELF-CONTAINED MAXIMUM CLASS SIZE **	AGE***
Other Health Impaired	Medical Educational	Chronic or acute health problems which adversely affect child's educational performance	10	0-21
Seriously Emotionally Disturbed	Psychological--by psychologist or psychiatrist Educational	Emotional problems affecting performance in regular class	10	4-21
Learning Disabilities	Educational Psychological Classroom Observation Multidisciplinary team *Eligibility Regulations--See Form 5	Severe discrepancy between achievement and intellectual ability which is not correctable without special education and related services	10	4-21
Speech OR Language Impaired	Screening/ Individual diagnosis and assessment Screening/ Individual diagnosis and assessment	Indication of disorder, deviation or general developmental delay in communication skills Receptive and expressive disorders, auditory perceptual difficulties	Maximum case load of 75 For laboratory case load information see page 8.	0-21 0-21
Homebound	Physician's Statement --- Physician's Statement	Illness --- Pregnant girls	3 one-hour periods per week	5-21
Itinerant Teacher Direct Services Homebased --- Indirect Services	Psychological Educational Developmental Medical	Needs of individual handicapped child	Maximum case load of 25 --- Maximum case load of 40	0-21 --- 0-21

* Following the law, all eligibility placement will be done by a team. Individual needs and appropriateness must be considered.

** Class size is based on a full-time special teacher. Less than full-time, the class size will be prorated. Example: a half-time lab teacher could serve 13 students. **NOTE: See page 8 for laboratory or resource room sizes.**

*** Severely handicapped children may begin receiving special education services at birth. These children are operationally defined as those functioning 50% or more below normal expectancy for their age.

SDE Form 9

STATE OF OKLAHOMA
John M. Folks, State Superintendent of Instruction
Individualized Education Program

1. Name Address of Student

2. School Birthdate Age

3. Date (date of writing) Grade (grade or applicable placement)

4. Statement of the Child's Present Levels of Education Performance

The statement of present levels of educational performance will be different for each handicapped child. Thus, determinations about the content of the statement for an individual child are matters that are left to the discretion of participants in the individualized education program meetings. However, the following are some points which should be taken into account in writing this part of the individualized education program.

a. The statement should accurately describe the effect of the child's handicap on the child's performance in any area of education that is affected, including (1) academic areas (reading, math, communication, etc.), and (2) nonacademic areas (daily life activities, mobility, etc.)

NOTE: Labels such as "mentally retarded" or "deaf" may not be used as a substitute for the description of present levels of educational performance.

b. The statement should be written in objective measurable terms, to the extent possible. Data from the child's evaluation would be a good source of such information. Test scores that are pertinent to the child's diagnosis might be included, where appropriate. However, the scores should be (1) self-explanatory (i.e., they can be interpreted by all participants without the use of test manuals or other aids), or (2) an explanation should be included. Whatever test results used should reflect the impact of the handicap on the child's performance. Thus, raw scores would not usually be sufficient.

c. There should be a direct relationship between the present levels of education performance and the other components of the individualized education program. Thus, if the statement describes a problem with the child's reading level and points to a deficiency in a specific reading skill, this problem should be addressed under both (1) goals and objectives, and (2) specific special education and related services to be provided to the child.

5. Summary Statements of Strengths and Weaknesses

Information for these statements should be taken from teacher and parent observations, the psycho-educational evaluation and other pertinent sources. These statements should address a child's special learning skills and needs, i.e., verbal/language skills, motor skills, behavior, etc.

6. Statement Regarding Reason for Removal from the Regular Educational Environment

Describe unsatisfactory performance experienced in regular educational environment even with adaptation.

7. Annual Goals

The annual goals in the individualized education program are statements which describe what a handicapped child can reasonably be expected to accomplish within a twelve month period in the child's special education program. There should be a direct relationship between the annual goals and the present levels of educational performance.

8. Short Term Instructional Objectives (Measurable)

"Short term instructional objectives" (also called "individualized education program objectives") are measurable, intermediate steps between a handicapped child's present levels of educational performance and the annual goals that are established for the child. The objectives are developed based on a logical breakdown of the major components of the annual goals, and can serve as milestones for measuring progress toward meeting the goals.

In some respects, individualized education program objectives are similar to objectives used in daily classroom instructional plans. For example, both kinds of objectives are used (1) to describe what a given child is expected to accomplish in a particular area within some specified time period, and (2) to determine the extent to which the child is progressing toward those accomplishments.

In other respects, objectives in individualized education programs are different from those used in instructional plans, primarily in the amount of detail they provide. Individualized education program objectives provide general benchmarks for determining progress toward meeting the annual goals. These objectives should be projected to be accomplished over an extended period of time (e.g., an entire school quarter or semester). On the other hand, the objectives in classroom instructional plans deal with more specific outcomes that are to be accomplished on a daily, weekly, or monthly basis. Classroom instructional plans generally include details not required in an individualized education program, such as the specific methods, activities, and materials (e.g., use of flash cards) that will be used in accomplishing the objectives.

9. Specific Educational and Related Services

Specific educational services are programs, instruction and/or unique materials and equipment specially designed to meet the individual educational needs of the student. List the type of service delivery. For example: lab or resource room, self-contained classroom, itinerant teacher, home-based instruction, regular classroom with adapted material/equipment designed for the hearing, visually, orthopedically, or other impaired. If unique/adapted materials are not used, nothing need be listed. "Unique" materials are *not* texts or programs normally available in the regular classroom or lab.

Related services are developmental, corrective, and other supportive services which assist a handicapped child to benefit from special education. These are determined by the individualized education program team and may include transportation, speech/language therapy, psychological evaluations, counseling, and other services.

10. Position/Person(s) Responsible

Indicate position or person delivering the service. Parent and student should be included as appropriate.

11. Amount of Time

Estimate the time allocated to meet the specific objective, i.e., 30 minutes daily, one hour twice a week.

12. Beginning Date

Indicate the date service is to begin.

13. Ending Date

Indicate the projected date for meeting each objective.

14. Evaluation Procedures

List evaluation procedures to be used to determine if short term objectives have been met, i.e., standardized tests, teacher-made tests, observation(s), etc.

15. Objective Achieved

Indicate by writing yes or no if each objective has been achieved. This should be done at least annually.

16. Physical Education

Each handicapped child must be afforded the opportunity to participate in the regular physical education program available for nonhandicapped children. Adaptive physical education is required if needed (this must be addressed on the individualized education program with measurable objective). Check appropriate box. Explain if *not applicable* is checked, i.e., medical, requirements completed, etc.

17. Vocational-Technical Education and Vocational Rehabilitation

Every eligible handicapped student must be afforded the opportunity to participate in vocational skills training and rehabilitative services as deemed necessary by the individualized education program team. This decision is based on the student's vocational needs as would enhance his/her transition from school to independent living. The rehabilitation counselor and skills instructor must be involved in the determination of appropriate programming and services. This must be addressed on the individualized education program with measurable objectives.

18. Amount of Time in Regular Classroom(s)

The amount of time should be listed as appropriate for the situation: minutes, hours, periods, portion of the day, percentage of time of the school day, etc. Address specific adaptions that may be necessary to implement objectives in regular classrooms.

19. Comments

Include any relevant information about the meeting not noted elsewhere on the individualized education program.

20. Date to Review Individualized Education Program Meeting

Record the date of the next scheduled individualized education program meeting (must be at least annually).

21. Least Restrictive Environment

This documents team consideration of least restrictive environment.

22. Participants in Individualized Education Program Development

The team includes the child's parent, an administrator or his/her representative, the special teacher, a regular teacher and others as appropriate. The individualized education program must be developed in a meeting. Parents must be present and participate at each meeting or are afforded the opportunity to participate as outlined on page 32 of this manual.

23. State Mandated Group Testing

This documents parent's request and subsequent permission for this student to participate in the state mandated testing.

STATE DEPARTME
John M. Folks, State Superin
INDIVIDUALIZED EI

Name _____ School _____

Address _____ Grade _____

Statement of Child's Present Levels of Educational Performance_____

_____

_____

_____

_____

Annual Goals: _____

_____

_____

_____

_____

‡

Short Term Instructional Objectives (Measurable)	Specific E & Relate

NT OF EDUCATION
endent of Public Instruction
UCATION PROGRAM

_____ Date _____

Birthdate _____ Age _____

Statement of Strengths: _____

_____

_____

Statement of Weaknesses: _____

_____

_____

Give reason for removal from the regular educational environment:

_____

_____

_____

ducational d Services	Position/Persons) Responsible	Amount of Time	Beginning Date	Ending Date	Evaluation Procedures	Objective Achieved

Short Term Instructional Objectives (Measurable)	Specific Ed & Related

ucational Services	Position/Person(s) Responsible	Amount of Time	Beginning Date	Ending Date	Evaluation Procedures	Objective Achieved

Short Term Instructional Objectives (Measurable)	Specific Educational & Related Services	Position/Person(s) Responsible
Physical Education Regular ☐ Not Applicable ☐ Explain:		
Adaptive ☐ Objective:		
Vocational Technical Education Yes ☐ Objective:		
No ☐ Explain:		
Vocational Rehabilitation Yes ☐ Objective:		
No ☐ Explain:		
Amount of time in regular classroom(s) _____ Adaptations: No ☐ Yes ☐ Objective:		

Comments: _____

_____

_____

_____

_____

_____

Date of Next IEP meeting _____

Least Restrictive Environment:

All team members agree that this IEP represents the least restrictive environment for this student. Yes ☐ No ☐

If no, explain:

	Amount of Time	Beginning Date	Ending Date	Evaluation Procedures	Objective Achieved

Participants in IEP Team Meeting

Parent(s) _____

Special Education Teacher _____

Regular classroom Teacher _____

Administrative Representative _____

Others: _____

Parents Present Yes ☐ No ☐

Participation in state mandated group testing requested by parents Yes ☐ No ☐

85

I. Confidentiality Procedures

The implementation of the Education for All Handicapped Children's Act requires the collection, storage, disclosure, and destruction of personally identifiable information. The local agency shall protect the confidentiality of all personally identifiable information as set forth in local agency policy. Each agency shall develop a policy in accordance with all federal regulations and state statutes or policies regarding educational records including Education for All Handicapped Children's Act, the Family Education Rights and Privacy Act of 1974, Education Department General Administrative Regulations, Oklahoma Statutes, and the Oklahoma State Plan for the Education of the Handicapped. The local agency shall make this policy available to the public annually.

One person in each local agency shall assume responsibility for ensuring the confidentiality of any personally identifiable information. Persons collecting or using personally identifiable information shall be trained by the local agency annually in confidentiality policies and procedures.

Regardless of the location for delivery of services, (in-district, cooperative, out-of-district, public or private institution, etc.) the local education agency shall maintain confidential records for all residents receiving special education.

All confidential records for handicapped students will be kept in a separate folder and not in the child's regular school cumulative folder. These records will be kept in a secure, locked area.

Each local education agency/public agency shall provide parents on request a list of the types and locations of education records collected and maintained by the local education agency. Confidentiality procedures are to be posted around each school building at strategic locations.

The following documents should be considered pertinent to the confidential file for each handicapped child:

1. Confidential Record Signature Sheet
2. Referral for Evaluation
3. Parent Permission Form (signed)
4. Evaluation Report/Testing Results
5. Learning Disabilities Team Summary
6. Notification of Meeting
7. Record of Parent Contacts
8. Categorical Eligibility Statement
9. Current Individualized Education Program (with all signatures)
10. Review of Placement/Other Information as needed, such as adaptive behavior information, medical records, speech or language evaluation, auditory evaluation, eye report, etc.
11. Confidentiality Procedures
12. Release of Information

To facilitate the updating process, individual files should have information arranged in chronological order, with the current or most recent individualized education program and other documents at the front of the folder.

Documentation of all actions, protests, challenges and recommendations by the parents/guardians for eligibility, individualized education program or annual review purposes must be documented and included in the confidential file. Documentation must include date, nature of contact, and reason why parents/guardians were unable or unwilling to attend meetings.

Record Access--Parents have the right to inspect and review any education records relating to their child. The local education agency will respond to a request without unnecessary delay and in no case longer than 45 days after the request is made. If the record contains information on more than one child, parents shall have access only to the information about their child. Access rights include:

1. The right to a response to reasonable requests for explanation and interpretation of the records;

2. The right to request that the agency provide copies of the records containing the information if failure to provide those copies would effectively prevent the parents from exercising the right to inspect and review the records. (A minimal fee for copies of the records which are made for parents may be charged if the fee does not effectively prevent the parents from exercising their right to inspect and review those records. A fee to search for or retrieve information may not be charged.)

3. The right to have a representative of the parents inspect and review the records.

4. Each agency shall maintain, for public inspection, a current listing of the names and positions of those employees who may have access to confidential information. The following persons have access to the records:

   Special education teacher
   Regular teacher
   Administrator and designated administrative personnel
   Counselor (including vocational rehabilitation)
   State Department of Education personnel

Vocational-technical education personnel
Parents/guardian
Student (if appropriate and 18 years old)
Related service providers
Paraprofessionals
Student teachers
School Nurses
Social Workers

Anyone not on the agency's current listing must have parental permission to access confidential records. A form must be kept in each handicapped student's folder to record who accessed the records, on what date, and the purpose.

An agency may presume that the parent has the authority to inspect and review records relating to his or her child unless the agency has been advised that the parent does not have the authority as a result of a court order in such matters as guardianship, separation, and divorce.

Parents may request amendment of records. A parent who believes that the educational information/records collected, maintained, or used are inaccurate, misleading, or violate the privacy or other rights of the child may request the school district to amend the records. The local education agency shall decide whether to amend the information within a reasonable period of time after receipt of the request (45 days).

If the local education agency decides to refuse to amend the information, it shall inform the parent of the refusal and advise the parent of the right to a hearing. On request, the local education agency has a responsibility to provide an opportunity for a hearing to challenge information in educational records to ensure that it is not inaccurate, misleading, or otherwise in violation of the privacy or other rights of the child. A hearing challenging information in educational records shall be conducted according to procedures stated in the Family Educational Rights and Privacy Act (34 CFR 99.22).

If, as a result of the hearing, the local education agency decides that the information is inaccurate, misleading, otherwise in violation of the privacy or other rights of the child, it shall amend the information accordingly and so inform the parents in writing.

If, as a result of the hearing, the local education agency decides that the information is not inaccurate, misleading, or otherwise in violation of the privacy or other rights of the child, it shall inform the parent of the right to place in the records it maintains on the child a statement commenting on the information or setting forth any reasons for disagreeing with the decision of the local education agency.

Any explanation placed in the records of a child shall be maintained by the local education agency as part of the records as long as the record or contested portion is maintained by the local education agency. If the records of the child or the contested portion are disclosed by the local education agency to any party, the explanation must also be disclosed to that party.

The disclosure or transfer of confidential records used to provide special education shall be made according to local education agency policy. The local education agency policy should include the method of transfer of records to another local education agency and circumstances which require written parental permission before disclosure or transfer.

The release of confidential student information will be in accordance with the following guidelines:

1. Each local education agency will define directory information. Directory information may be released WITHOUT written parent permission. Parents will be sent a written notice that the records have been released and to whom. Directory information may include:

   a. Basic identifying information

      (1) Name and sex
      (2) Birthdate and birthplace
      (3) Home address and telephone number
      (4) Parent or guardian name, address, and telephone number
      (5) Names and dates of school attendance, location, and principal's name
      (6) Current health information, e.g., allergies, diseases, immunizations

   b. Functioning or performance information

      (1) Results of *group* standardized achievement tests
      (2) Results of *group* standardized intelligence and aptitude tests
      (3) Academic information

2. Information that REQUIRES written parent permission before release includes:

   a. Individual evaluations

      (1) All specialized records of professionals who have screened, assessed and/or evaluated the students, i.e., psychologist, psychometrist, social worker, diagnostician, physician's medical assessment, or any individual evaluation as it pertains to placement in a school program

      (2) Specialized reports from outside agencies or specialists, i.e., private schools, social service agencies, vocational rehabilitation, hospitals

   b. Anecdotal records

   c. Test results, prescriptive learning plans, and eligibility information from a regional education service center to a school district other than the school district where the child was evaluated

All confidential records will be maintained for at least five years from the time they are generated.

After five years or parent request and determination that the records are no longer needed they may be destroyed. Parents must be notified 60 days before destruction and will be offered the opportunity to obtain the documents.

All parental rights regarding educational records pass to the child upon reaching the age of majority (age 18) or when attending an institution of post secondary education unless a specific statute or court order directs otherwise.

The State Department of Education may maintain, give access and/or release personally identifiable data to other agencies in order to facilitate monitoring placements, provisions of services for children in need of special assistance or prolonged assistance, and to enforce legal requirements. Should a participating agency need to disclose personally identifiable

data other than for the purpose of which the data has been collected, the agency shall first obtain informed parent consent.

J. Step-by-Step Service Delivery Procedures

Step 1--SCREENING (all students) conducted by the local education agency, regional education service center, or other agencies.

Step II--REFERRAL (children with suspected special needs) initiated by school, a parent, or other agencies.

Step III--EVALUATION (by multidisciplinary team) Written parental consent is required *before* the student is evaluated. Parents must be given a written statement of their rights.

Step IV--CATEGORICAL ELIGIBILITY/STATEMENT Timeline: Within 15 calendar days of receipt of evaluation results, a team must determine categorical eligibility. Team composition: parent, administrator or administrative representative, the regular teacher, special teacher, and others as appropriate.

A special eligibility team is required for learning disabilities.

Step V--INDIVIDUALIZED EDUCATION PROGRAM/PLACEMENT TEAM (a team decision) Timeline: Within 30 calendar days of declared categorical eligibility. An individualized education program must be written before physical placement of student is made and services begin because the individualized education program lists the type of program, amount of time in the program, related services, and other required information.

If the categorical eligibility team declares a child to be eligible for special education, parental consent must be obtained before initial placement occurs. If parental consent to this placement is refused, the school/public agency must request a due process hearing to determine if the child may be initially provided special education without parental consent. Any changes in a child's special education program, after the initial placement, are subject to the prior notice and individualized education program requirements. These changes may be made without parental consent *if the above requirements are met*. Every reasonable effort should be made to involve parents in this decision making. The forms located in the appendix of this manual may be used to document efforts to: contact parents, notify parents of meetings to discuss their child's educational program and any changes that may be appropriate, and provide opportunities for parent participation. Written notice must be given to the parents of a handicapped child a reasonable time before a school/public agency proposes or refuses to initiate or change the identification, evaluation, educational placement, or provision of a free appropriate public education for the child.

The individualized education program/placement team meeting is the responsibility of the home district. A child cannot be sent to a co-op, vocational-technical school, state school, private school, or another district until this has been completed. The sending district (home) is responsible for writing the individualized education program, but the receiving school shall have a representative on this team. The home district may allow a co-op director to serve as its administrative representative on the IEP team if the home district and co-op have a written agreement or policy describing the co-op director's role. All blanks on the individualized education program are to be completely filled out.

Step VI--REVIEW OF INDIVIDUALIZED EDUCATION PROGRAM/PLACEMENT Timeline: At least annually; however, it may be written into the individualized education program that the review will be conducted more often as needed.

The review is done by a team (including parent) and a new individualized education program is to be written during the annual review meeting. For those students in their junior/senior year the annual review team should include a vocational rehabilitation counselor and others as appropriate for the transitional planning of the individualized education program and individualized written rehabilitation plan.

Step VII--Repeat of Steps III, IV, V, VI (see above) All handicapped children must be evaluated at least every three years. This may be done more often if needed. Need will be determined on the individual child's progress or lack of progress. Parental *written* permission is required for each evaluation.

XI. DUE PROCESS HEARING AND APPEAL PROCEDURES

Introduction

Under the authority of the Education for All handicapped Children Act of 1975, Public Law 94-142, and 70 O.S. Supp. 1987, § 3-104, and the Oklahoma Administrative Procedures Act, 75 O.S. 1971, § 301 et seq., the Oklahoma State Department of Education in keeping with the constitutional rights and privileges accorded its citizens, does hereby establish the following policies and procedures to guarantee due process protection to children and their parents in regard to identification, evaluation and educational placement of a child. *Each public agency shall access the due process system established and implemented by the State Department of Education.*

A. Due Process Hearing

1. A major element of due process is that an opportunity is provided for the creation of a forum that will provide an objective review of the parent-school disagreement and ultimately produce an objective decision resolving the dispute. Regardless of the formal and informal steps leading to a hearing and the many procedural provisions that must be met in the hearing situation itself, the key concept is that the final decision of the hearing officer will be impartial.

2. A request for a due process hearing may be initiated at any time and the decision shall be rendered within 45 calendar days of the time the request was presented.

B. Who May Request a Hearing and for What Purpose?

1. Parents or guardians may request a hearing for any of the following reasons:

   a. To challenge the initiation of the identification, evaluation or educational placement of the handicapped or purported to be handicapped child.

   b. To challenge a change of the identification, evaluation, or educational placement of the handicapped, or purported to be handicapped, child.

c. To challenge the refusal of the local education agency to initiate or change the identification, evaluation, or educational placement of the handicapped, or purported to be handicapped, child.

d. To challenge the results of an educational evaluation on which an educational placement recommendation was made.

e. To challenge the present or recommended educational placement of their handicapped, or purported to be handicapped, child.

f. To challenge whether an educational program is free and/or appropriate for a handicapped, or purported to be handicapped, child.

2. The local education agencies may request a conference and/or hearing for any of the following reasons:

a. To challenge the refusal of a parent to give permission to test a child who is believed to be handicapped.

b. To challenge the refusal of a parent to give permission to place a handicapped child in a special education program.

c. To challenge the refusal of a parent to give permission to change or alter the identification, evaluation, or educational placement of a handicapped child.

C. How is a Request for a Due Process Hearing Initiated?

A request for a due process hearing may be initiated in the following manner:

1. Parents or guardians must present a written request for a hearing to the local school administrator stating the child's name, date of birth, current grade or class placement, and give the reasons for challenging the identification, evaluation, classification, or placement or appropriateness of the education of the child in question.

2. The local education agency must present a written request for a hearing to the State Department of Education, and must provide written notice to the parents, in the primary language of the home, informing them that they are filing a request for a hearing. This notice shall be sent by certified mail, return receipt requested, on the date the request for a hearing is filed with the State Department of Education.

D. The Hearing Officer

The term "impartial hearing officer" shall mean the appointment of a trained individual by the State Department of Education, Special Education Section, for the purpose of presiding at due process hearings.

It shall be the responsibility of the State Department of Education to ensure that the hearing officer assigned to a particular hearing is unbiased. Any party to a due process hearing may challenge the assignment of a particular hearing officer. It shall be the responsibility of the State Department of Education to assign a new hearing officer to the case upon a showing that the appointed hearing officer is biased or other good cause.

E. Decision of the Hearing Officer

The decision of the hearing officer shall include findings of fact, reasons thereof, and conclusions thereon.

The decision of the hearing officer shall state that this decision is binding upon the parents or the child, if over the age of majority and upon the local education agency, its officers, employees, and agents, subject to procedures for administrative or judicial appeal, and that any questions regarding appeal procedures may be directed to the State Department of Education, Special Education Section, Hodge Education Building, Oklahoma City 73105-4599. A statement of the procedures to be used for appealing such decision shall be included in the decision.

F. Conduct of Administrative Appeals

Appeals must be initiated by a parent or by the local education agency and must be made within 30 calendar days after receipt of the decision. The appeal of a decision of the hearing officer will be reviewed by the State Board of Education's impartial designee. Each appeal officer will meet the same qualifications required of all hearing officers. All requests for appeals should be mailed to the Oklahoma State Department of Education, Special Education Section. This section shall ensure that not later than 30 calendar days after the receipt of a request for a review, a final decision will be reached and a copy of the decision mailed to each of the parties.

If there is an appeal, the State Department of Education shall conduct an impartial review of the hearing. The official conducting the review shall:

1. Examine the entire hearing record;

2. Ensure that the procedures at the hearing were consistent with the requirements of due process;

3. Seek additional evidence if necessary. If a hearing is held to receive additional evidence, the rights in (34 CFR 300.508) apply;

4. Afford the parties an opportunity for oral or written argument, or both, at the discretion of the reviewing official;

5. Make an independent decision on completion of the review; and

6. Give a copy of written findings and the decision to the parties.

7. The decision made by the reviewing official is final, unless a party brings a civil action under (34 CFR 300.512).

Each public agency shall access the due process system established and implemented by the State Department of Education.

G. Extension of Time

A due process hearing officer or appeal officer may grant a specific extension of time beyond the periods set out at the request of either party, i.e., the 45 calendar days for a hearing and the 30 calendar days for an appeal.

Note: Upon request for a due process hearing, the Special Education Section will send both parties (school/parent) the *Guidelines for Parents and School Administrators, Due Process in Special Education* manual giving the details of each party's rights, responsibilities, and procedures of the hearing..

C. Category Definitions, State Regulations and Class Size

Definitions of "handicapped children."* The terms used are defined as:

1. "Deaf" means a hearing impairment which is so severe that the child is impaired in processing linguistic information through hearing, with or without amplification, which adversely affects educational performance.

2. "Deaf-Blind" means concomitant hearing and visual impairments, the combination of which causes such severe communication and other developmental and educational problems that they cannot be accommodated in special education programs solely for deaf or blind children.

* (34 CFR 300.5)

3. "Hard-of-Hearing" means a hearing impairment, whether permanent of fluctuating, which adversely affects a child's educational performance but which is not included under the definition of "deaf" in this section.

4. "Mentally Retarded" means significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period, which adversely affects a child's educational performance.

5. "Multihandicapped" means concomitant major impairments (such as mentally retarded--blind, mentally retarded--orthopedically impaired, etc.), the combination of which causes such severe educational problems that they cannot be accommodated in special education programs solely for one of the impairments. The term does not include deaf-blind children.

6. "Orthopedically Impaired" means a severe orthopedic impairment which adversely affects a child's educational performance. The term includes impairments caused by congenital anomaly (e.g., clubfoot, absence of some member, etc.), and impairments from other causes (e.g., cerebral palsy, amputations, and fractures or burns which cause contractures).

7. "Other Health Impaired" means having an autistic condition which is manifested by severe communication and other developmental and educational problems; or having limited strength, vitality or alertness, due to chronic or acute health problems such as a heart condition, tuberculosis, rheumatic fever, lead poisoning, leukemia, or diabetes, which adversely affects a child's educational performance.

8. "Seriously Emotionally Disturbed" is defined as follows:

   a. The term means a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree, which adversely affects educational performance:

      (1) An inability to learn which cannot be explained by intellectual, sensory, or health factors;

      (2) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers;

      (3) Inappropriate types of behavior or feelings under normal circumstances;

      (4) A tendency to develop physical symptoms or fears associated with personal or school problems.

   b. The term includes children who are schizophrenic. The term does not include children who are socially maladjusted, unless it is determined that they are seriously emotionally disturbed.

9. "Specific Learning Disability" means a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, which may manifest itself in an imperfect ability to listen, think, speak, read, write, spell, or to do mathematical calculations. The term includes such conditions as perceptual handicaps, brain injury, minimal brain dysfunction, dyslexia, and developmental aphasia. The term does not include children who have learning problems which are primarily the

result of visual, hearing, or motor handicaps, of mental retardation, emotional disturbance, or of environmental, cultural or economic disadvantage.

10. "Speech or Language Impaired" means a communication disorder, such as stuttering, impaired articulation, a language impairment, or a voice impairment, which adversely affects a child's educational performance.

11. "Visually Handicapped" means a visual impairment which, even with correction, adversely affects a child's educational performance. The term includes both partially seeing and blind children.

TYPES OF SERVICES

1. Consultant --
   Supportive assistance. Direct contact with teacher; indirect contact with students.
2. Itinerant --
   Direct student contact. Teacher may serve two or more schools.
3. Resource Room --
   Direct student contact. Student comes to resource room from regular class. Maintains identification with regular classroom.
   a. Categorical --
      Only students of a particular special education category.
4. Self-contained--
   Direct student contact. Students may go from special class to regular class as their abilities permit, but identification is with the special classroom.

Other Important Special Education Terminology

1. LRE: Least Restrictive Environment
   Insurance that the special student is educated with his nonexceptional peers to the maximum extent possible.
2. Comprehensive Evaluation
   An evaluation (test procedure) of physical, psychological and educational data which takes into account the school, home, and community.
3. Exceptional Children
   Children who differ from the typical school population to the extent that special education and support services are required.
4. I.E.P. - Individual Education Program
   A written statement of the special education and related services required.
5. Mandate
   A legislated requirement for action.
7. P. L. 94-142
   Federal mandate to insure a free, appropriate education for handicapped learners.
8. State Plan
   State mandate to insure that all federal and state mandates are carried out at the local level.
9. LEA District Plan
   Document which indicates how the local program will meet state and federal mandates.
10. Paraprofessional - Paras
    VERY SPECIAL PEOPLE !

    A special teacher qualified to assist certified teachers in the instruction of exceptional learners.

SPEECH/LANGUAGE DEVELOPMENT

DISCIPLINE TRAINING FOR THE CHILD WITH SPEECH AND LANGUAGE DELAY

For optimum speech and language learning, the child needs the security and emotional stability provided by good discipline in the home and at school. This training also aids in the development of self-control, attention, and cooperation essential for adjustment to formal learning situations.

There is apparently no relationship between the degree of original behavior (distractibility, perseveration, temper tantrums) and the eventual progress this child may make in language development. Many children who have been extremely distractible and perseverative, eventually become well organized in social behavior. But this change in behavior appears to be directly related to the establishment of routine by the parents and teachers (which includes firm but kind discipline) and a professionally planned educational program for the child.

The approach to discipline training with the communication-handicapped child is not basically different from that needed for the child with normal speech and hearing. The difference lies only in the greater importance of an organized, intelligent, and consistent program for this child. Discipline is imperative, then, because

1. You often cannot make the child understand an explanation for your request or demand.
2. The child often cannot hear or perceive danger signals; therefore, he must respect and accept restrictions on his activity and place of play.
3. Frustration level from communication failures is already high, and we must keep other frustrations to a minimum.

What is discipline? It is a process of training - training a child to become self-disciplined; self-controlled; it includes punishment; but not oppression or abuse. Discipline fosters growth and development and leads to usefulness and happiness. Every child needs the security of limits. He needs rules and stop lights and guiding signs to get him through life. By setting limits, parents and teachers earn the right to be respected and obeyed.

Now let us consider a few helpful suggestions for a satisfactory training program in self-discipline.

1. **Routine and rules**

   Any child is decidedly more secure when he knows what he is to do at all times. If a home or school has a regular sequence of daily activity and some definite house-rules of behavior, then bickering, argument and tensions are reduced. The child is more likely to be physically and emotionally at ease and, therefore, contentedly follows his regime.

2. **Do's and Don'ts**

   Reduce do's and don'ts by following this rough rule-of-thumb. Include regulation--
   a. if they are necessary for the child's safety and for the well-being of the rest of the family or classroom.
   b. if they are necessary for the protection of the family's property or for the property of others in the classroom.
   c. if they are necessary for the character building of the child.

   If do's and don'ts are necessary only for the convenience or comfort of the adult, try to avoid them.

3. **Reasonability; Avoid Impossible Demands**

Don't invariably ask for the undesirable or prohibit the desirable. If a behavior problem exists, or if you are trying to improve on poor habits of compliance with instructions, try this method:

a. Start by asking the child to do the things you know he already likes to do in order to change this negative attitude toward direction.
b. Next, ask him to do neutral things that that are neither particularly pleasant or unpleasant to him.
c. Finally, work up to the task or directions which have been disagreeable to him.

4. **"Tuning In"**

Give the child time to listen - time to "tune-in" to what you are saying. We assume that our direction was given attention and perception, and then think that the child is ornery and stubborn if he fails to respond. Get his attention before giving a direction.

5. **Verbal or Vocal Response**

Insist on a verbal response from the child when given a command. The response clearly indicates whether or not the instruction was heard or understood. The particular words used ("yes, Ma'am," or "yes, Mommy,") are not as important as the fact that some response be made.

6. **Following Through**

Immediate follow-up of an ignored important instruction, once you have established that it was heard or received, is essential. If you do follow through, the child will know you "mean business," and few warnings will be necessary - save perhaps an occasional preliminary "Count down" for the very young ones. Also, you will be able to remain calm and controlled and will be more likely to avoid unrealistic unenforceable threats, as well as apology, guilt, and "loss of face".

7. **Consistency**

Perhaps only complete rejection disturbs a child's security more than does inconsistency. If you expect to get consistency in response to direction, you must provide a consistent stimulus and a consistent expectation of performance from day to day. A reward or punishment which is consistent in frequency of occurrence, in kind, and in application is essential. Also essential is a united front by both parents and teachers on all policy matters. Let the child always know what to expect of you, and expect the best of him in turn. Chances are, he will not only accept even disagreeable direction but will do so willingly in order to win your approval.

8. **Praise**

Praise more than you punish, and this means praise of effort as well as performance. Trying hard shows responsibility even though results aren't perfect. However, be sure that the praise is sincere; children will quickly sense if it is false.

9. **Bribes**

Never resort to bribes - "I will give you this toy if you stop that". Bribes backfire and can cause great harm. They suggest the opposite behavior, encourage deals, and promote the placing of a price tag on being good and responsible.

10. **Differentiate Between Childhood Irresponsibility and Willful Defiance**

Be willing to guide a child through childish irresponsibility with patient teaching, avoiding ridicule and put-downs. Also be willing to discipline with firmness any act of willful defiance. Both responses are indicative of love and a sincere desire to help shape the child's behavior.

11. **Punishment: Time-out Spanking, Pressure Points, Withdrawal of Rewards, Logical Consequences**

This kind of punishment is not as important as the fact that it should be private, individualized, appropriate,consistent, calmly and objectively administered, and not humiliating. Be firm but kind, and do not be afraid of losing the love of your child when punishment becomes necessary. However, do not continue punishing for the same repeated offense. Recognize that a reason usually exists for most repeated, socially unacceptable behavior. Look for fatigue or basic needs such as food, drink, or elimination. Look to his misunderstanding of what has been said to him and to his lack of understanding of what you expect him to do. Consider his feelings or jealously and his failure to get socially acceptable attention.

12. **Avoid Perfection**

Let him make honest mistakes and accidents. Don't be afraid to admit that even you sometimes make mistakes. Children must be encouraged patiently when childish irresponsibility causes mistakes or inability to behave as the parent/teacher wishes.

13. **Trust and Confidence**

Show your child that you have faith in him by the responsibility you give him. Expect him to perform and he will. Believe the best and you are much more likely to get the best.

14. **Love**

Don't be afraid of losing his love by direction, restraint, or punishment. A child can understand that it is because you love him that discipline and direction are necessary. Proper discipline actually increases a child's respect and love for the parent or teacher. On the other hand, don't be afraid of spoiling him with kindness, affection, and consideration. It is not love, but inconsistency and indecision, that spoils a child.

15. **Example**

Good behavior, like most desirable habits you hope for and work toward in your child, is caught better than taught. This would be especially true of the child handicapped in hearing or language understanding. You can moralize until you are hoarse, but it doesn't mean much unless the example of conduct you provide is the one you want him to follow.

ORIENTATION TO DEAF-BLIND AND MULTIHANDICAPPED

NICHCY
NATIONAL INFORMATION CENTER FOR HANDICAPPED CHILDREN AND YOUTH
P.O. BOX 1492 WASHINGTON, D.C. 20013

Spina Bifida

Definitions

Spina bifida means cleft spine, which is an incomplete closure in the spinal column. The three types of spina bifida (from mild to severe) are:

1. SPINA BIFIDA OCCULTA: There is an opening in one or more of the vertebrae (bones) of the spinal column without damage to spinal cord.
2. MENINGOCELE: The meninges, or protective covering around the spinal cord, have pushed out through the opening in the vertebrae in a sac called the "meningocele". However, the spinal cord remains intact. This form can be repaired with little or no damage to the nerve pathways.
3. MYELOMENINGOCELE: Not only are there openings in vertebrae, but the spinal cord itself does not close. It usually protrudes from the back.

Prevalence

Approximately 40% of all Americans have spina bifida occulta, but very few of them ever know it. The two other forms, collectively referred to as "spina bifida manifesta", occur in approximately one out of every thousand births. Of these, 4% have the meningocele form and 96% have myelomeningocele.

Characteristics

The effect of myelomeningocele, the most serious form of spina bifida, may include muscle weakness or paralysis below the cleft, loss of sensation below the cleft, and loss of bowel and bladder control. In addition, since the spinal cord is the system by which fluid is normally drained from the brain, the fluid may build up and cause hydrocephalus or accumulation of fluid on the brain. 70–90% of the children born with spina bifida have hydrocephalus. Hydrocephalus is controlled by a surgical procedure called "shunting" which relieves the fluid buildup in the brain area. Hydrocephalus may occur without spina bifida, but the two defects often occur together. If a drain (shunt) is not implanted, the pressure buildup can impair the functioning of the brain.

Educational Implications

Although spina bifida is relatively common, until recently most children born with a myelomeningocele died shortly after birth. Now that surgery to close the spine can be performed in the first 48 hours of life, children with spina bifida are much more likely to live. Quite often, however, they must have a series of operations throughout their childhood. School programs should be planned with this consideration in mind.

Many children with myelomeningocele need training to learn to manage their bowel and bladder functions. Some require catheterization, or the insertion of a tube to permit passage of fluids. Catheterization in the schools has been an issue in the courts of some states. Where this issue has been litigated, the courts have held that clean, intermittent catheterization is a related service when it is necessary to help the child benefit from and have access to special education and related services.

Often children with spina bifida who also have a history of hydrocephalus experience learning problems. They may have difficulty with paying attention, expressive and receptive language, reading, and math. Early intervention with children who experience learning problems can make it possible to integrate them with their non-disabled peers when they begin school.

Successful integration of a child with spina bifida into a school attended by non-disabled young people sometimes requires changes in school equipment or curriculum. In the same way as a student placement should be the least restrictive one appropriate for him or her, the day-to-day school pattern also should be as "normal" as possible. In adapting the school setting for the child with spina bifida, architectural factors should be considered. Section 504 of the Rehabilitation Act of 1973 requires that programs receiving Federal funds make their programs accessible. This could mean structural changes (for example, adding elevators or ramps) or schedule or location changes (for example, offering a course on the ground floor). Recent legislation provides up to $40 million in Federal funds throughout the nation for renovation of school buildings to make them accessible.

Children with spina bifida need to learn mobility skills, often with the aid of crutches, braces, or wheelchairs. It is important that all members of the school team and the parents understand the child's physical capabilities and limitations. Physical disabilities like spina bifida can have profound affects on children's emotional and social development. To promote growth, parents and teachers should avoid overprotection and encourage children to take risks within the limits of safety and health. Teachers and classmates should also understand that, although children with spina bifida are physically handicapped, they are more like their classmates than different from them.

Tourette Syndrome. These can be specifically identified and teachers can compensate but again, early and correct diagnosis is necessary.

Our chapter is affiliated with the national Tourette Syndrome Association. We are active throughout the state of Oklahoma and our activities are conducted entirely by volunteers. We provide the following at no cost:

General or basic information
List of physicians experienced in diagnosing and treating this disorder.
Information about educational implications to educators and teachers.
Medical information to doctors, nurses and other health professionals.
Films and videotapes.

Our chapter sponsors a resident camp for children that have Tourette Syndrome and their brothers and/or sisters. The one-week camp is in June and held at Camp Wah-Shah-She, near Bartlesville. Children from throughout the United States have attended.

Information, films, videotapes, info about camp or any other help is available by writing P. O. Box 761, Bartlesville, OK 74005 or by calling (918) 336-3086.

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Cerebral Palsy

Definition

According to the United Cerebral Palsy Association, cerebral palsy is a group of disabling conditions caused by damage to the central nervous system. "Cerebral" refers to the brain, while "palsy" describes lack of muscle control that is often (but not always) a nervous system symptom. Cerebral palsy can be mild or severe.

Damage to the brain may occur before or during birth because of illness in pregnancy, premature delivery, or lack of oxygen supply to the baby; or it may occur early in life as a result of an accident, lead poisoning, illness, child abuse, or other factors.

Incidence

Approximately 700,000 Americans (or 16 out of every 5,000) have some degree of cerebral palsy. 10,000 babies with the disorder are born each year, and another 2,000 acquire it in the early years of life.

Characteristics

Four main descriptions of cerebral palsy have been identified:

1. Spastic, the most common type, which results in tense, contracted muscles;
2. Athetoid, which is characterized by constant uncontrolled movements; and
3. Ataxic, which is typified by poor sense of balance and depth perception.
4. A combination of the types of cerebral palsy listed above.

The effects of cerebral palsy depend on the extent and location of the brain damage. One or more of the following conditions may occur:

- seizures
- problems in vision, hearing or speech
- abnormal sensation or perception
- mental retardation
- impairments in arm and leg movement

Educational Implications

Early identification of cerebral palsy can lessen developmental problems and lead to appropriate treatment when it helps the most. Special educators and physicians have discovered that early intervention can make an important difference. Early intervention programs enlist parents and other family members in working with the child in specific activities. These activities, designed by therapist, provide the child with stimulation needed to overcome slower development which is part of cerebral palsy. Other forms of treatment of children with cerebral palsy may include speech and language therapy, occupational therapy, physical therapy, medical intervention and social services.

Among the services that the older child with cerebral palsy may need are: attendant care, continuing therapy, special education, counseling, vocational training, and recreation training. The services required will vary from person to person depending on the nature and severity of the handicap.

Important advances have taken place in the last decade which have a great affect on the long term well-being of children born with cerebral palsy. Advanced technology is being applied to the needs of severely disabled persons with cerebral palsy, including biofeedback, computers and engineering devices. Technological innovations made have been made in the areas of speech and communication, self-care, and adapting jobs. The future may bring even more significant applications.

Another other important development has been an increased ability of disabled persons, including those who are severely disabled, to live independently in the community. Independent living opportunities exist in the form of group, shared and supervised apartments, and of disabled individual living on their own in the community with appropriate support services. Independent Living Centers staffed and run by persons with disabilities have proven to be important resources for disabled persons. Treatment of cerebral palsy requires close cooperation among educational, medical and social services, the family and the individual. To promote growth, parents and teachers should avoid overprotection and encourage children to take risks within the limits of safety and health. Teachers and classmates should understand that, although children with cerebral palsy are physically handicapped, they are more like their classmates than different from them.

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Resources

Information on Cerebral Palsy

United Cerebral Palsy Associations
66 East 34th Street
New York, NY 10016
(212) 481-6300

National Easter Seal Society
2023 West Ogden Avenue
Chicago, IL 60612
(312) 243-8400

National Institute for Neurological and Communicative Disorders and Stroke
National Institute of Health, HHS
Building 31, Room 8A-06
Bethesda, MD 20205
(301) 496-5751

Information of Special Education

ERIC Clearinghouse on the Handicapped and Gifted
Council for Exceptional Children
1920 Association Drive
Reston, VA 22091
(793) 620-3660

Information on Equipment for Children with Disabilities

ABELEDATA
c/o National Rehabilitation Information Center
4407 8th Street NE
Washington, DC 20017
(202) 635-6090

Accent on Information
P.O. Box 700
Gillum Road and High Drive
Bloomington, IL 61701
(309) 378-2961

Information on Design of Accessible Facilities

Adaptive Environments Center
Massachusetts College of Art
26 Overland Street
Boston, MA 02215
(617) 266-2666

Information on Communication Aids

Trace Center Research and Development Center
314 Waisman Center
1500 Highland Avenue
Madison, WI 53706
(608) 262-6966

Information on Rehabilitation and Independent Living

National Rehabilitation Information Center
4407 8th Street, N.E.
Washington, DC 20007
(202) 635-5822

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Physical Disabilities and Special Health Problems

Definitions

Orthopedic or physical disabilities describe medical or structural conditions which may be serious enough to disrupt the child's development and require special attention in school. Typical examples of orthopedic or physical problems include disabilities present at birth (such as missing limbs, spina bifida, etc.), as well as physical problems resulting from other causes (such as contractures caused by burns or fractures, etc.). In addition, neurological problems, such as cerebral palsy, may be included in this category.

Health impairments may result in limited strength, vitality and/or alertness. Asthma, cardiac conditions, sickle cell anemia, epilepsy, and leukemia are examples of health impairments that could interfere with a child's education.

Prevalence

One half of one percent (.5%) is the figure usually cited in estimates of school aged children with physical or health impairments. Cerebral palsy accounts for a large part of this percentage, followed by spina bifida.

Characteristics

Physical disabilities can produce a variety of characteristics. Children may experience a wide range of restrictions on their activity, from little or none to a complete restructuring of daily life. The most severly affected children may require intensive medical and educational help.

Physical problems may interfere with children's motor functioning, communication, learning skills, or social development.

Educational Implications

The contributions of such related services as physical, occupational, and speech and language therapy are often central to the education of children with physical disabilities. The greatest progress is achieved when therapy suggestions are consistently applied in the child's home as well as in school. This carryover strengthens appropriate feeding, positioning, and language stimulation patterns.

Architectural factors must be considered. Section 504 of the Rehabilitation Act of 1973 requires that programs receiving Federal funds make their programs accessible. This could mean structural changes (for example, adding elevators or ramps) or schedule or location changes (for example, offering a course on the ground floor).

Sometimes the nature of the child's disability requires changes in school equipment or curriculum. In the same way as a student's placement should be the least restrictive one appropriate for him or her, the day-to-day school pattern also should be as "normal" as possible.

Physical disabilities can have profound effects on children's emotional and social development. To promote growth, parents and teachers should avoid overprotection and encourage children to take risks within limits of safety and health. Teachers and classmates should also understand that, although children with physical disabilities and health impairments may be physically handicapped, they are more like their classmates than different from them.

Technology holds great promise for making the life of a child with a disability more "normal." Computerized devices, for example, can help nonvocal, severely physically involved children communicate, perhaps for the first time.

Students who require recurring or longterm hospital care for their condition may need special services such as tutoring or homebound instruction to keep up with their class. Depending upon the nature and severity of the condition, counseling for the entire family may be helpful.

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Other Considerations

Recent scientific development conclude that preventive measures are effective in reducing the incidence of retardation. Some specific approaches to prevention include:

- Being sure that women are vaccinated for rubella at least three months before they become pregnant,
- Providing proper prenatal care for the mother-to-be, including attention to diet and providing the infant with an adequate diet,
- Checking for Rh factor incompatibility between mother and infant and preventing harm when it occurs by exchanging the baby's blood at the time of birth and providing special immunization for the mother, and
- Preventing children from eating paint containing lead and providing quick treatment if lead poisoning does occur.

Mental retardation has been defined traditionally as an irreversible condition. However, recent advance in technology have been such that there are strong indications that it may be possible within the foreseeable future to significantly enhance intellectual functioning and to reverse certain deteriorative processes. With the application of the current development of new knowledge, the scientific community is working to seek cures for disorders and conditions that cause mental retardation.

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Resources

American Association on Mental Deficiency
5101 Wisconsin Avenue, N.W., Suite 405
Washington, DC 20016

Council for Exceptional Children
Division on Mental Retardation
1920 Association Drive
Reston, VA 22091

International League of Societies for the Mentally Handicapped
12 Rue Forestiere
Brussels 5, Belgium

National Association for Retarded Citizens/US
P. O. Box 6109
2501 Avenue J
Arlington, TX 76011

National Head Injury Foundation
18A Vernon Street
Framingham, MA 01701

People First International
(Self Advocacy Group)
P. O. Box 12642
Salem, OR 97304

President's Committee on Mental Retardation
U.S. Department of Health & Human Services
Office of Human Development Services
Washington, D.C. 20006

Special Olympics, Inc.
1701 K Street, N.W., Suite 203
Washington, DC 20006

The Association for Persons with Severe Handicaps
7010 Roosevelt Way, N.E.
Seattle, WA 98115

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Down Syndrome

Definition

Down syndrome is the most common and readily identifiable genetic condition associated with mental retardation. It is caused by a chromosomal abnormality: for some unexplained reason and typically due to no one's fault, accident in cell development results in 47 instead of the usual 46 chromosomes. This extra genetic material changes the orderly development of body and brain.

Incidence

Approximately 4,000 children with Down syndrome are born in the U.S. each year, about 1 per 1,000 live births. Although parents of any age may have a child with Down syndrome, the incidence is higher for children born to women and men over 35. Most common forms of the syndrome do not usually occur more than once in a family.

Characteristics

There are over 50 clinical signs of Down syndrome, but it is rare to find all or even most of them in one person. Some common characteristics include:

- poor muscle tone
- slanting eyes with folds of skin at the inner corners (called epicanthic folds)
- white ("Brushfield") spots in the iris of the eye
- transverse crease on the palm (Simian crease)
- flat bridge of the nose
- short neck
- small head
- small mouth
- heart disorders in approximately ⅓ of people with Down syndrome
- a tendency to respiratory infections

Educational Implications

Shortly after a diagnosis of Down syndrome is confirmed, parents are encouraged to enroll their child in an infant stimulation/early childhood education program. These programs offer special instruction in the acquisition of language and teach specific exercises for gross and fine motor development while also working on cognitive, self-help, and social skills. Research has shown that stimulation during early developmental stages improves the child's chances of developing to his or her fullest potential. Continuing education, family involvement, and a stimulating home environment have also been found to have a positive effect on the child's overall development.

Children with Down syndrome develop in different ways and at different paces. Their level of retardation may range from mild to severe with the majority functioning in the mild range. Due to these individual differences it is impossible to predict their future school achievement.

The same general principles of instruction for any child with retarded development apply to a child with Down syndrome. Emphasis is placed on concrete rather than abstract concepts. Tasks and activities are taught in a step by step manner and prompt consistant feedback is continually reinforced. Children with Down syndrome must be helped to learn everyday tasks that non-handicapped children learn incidentally. It is important that all members of the school team and the parents understand the child's capabilities and limitations. To promote growth, parents and teachers should avoid overprotection and encourage children to take risks within the limits of safety and health. Teachers and classmates should also understand that children with Down syndrome are more like their classmates than they are different from them.

Medical/Health Implications

There is a wide variation in mental abilities, behavior and developmental progress in individuals with Down syndrome just as in the "normal" regime.

Individuals with Down syndrome are usually smaller than their "normal" peers and their physical as well as intellectual development is slower. Approximately one-third of babies born with Down syndrome have heart defects, most of which are now successfully correctable by surgery. Some individuals with Down syndrome are born with gastro-intestinal tract problems that can be surgically corrected.

A lowered resistance to infection makes children with Down syndrome more prone to respiratory problems.

Eye problems such as crossing and far or near sightedness are higher in the population with Down syndrome while hearing problems may result in mild to moderate hearing loss and speech difficulty.

Some individuals with Down syndrome suffer from a condition known as Atlantoaxial Dislocation. A misalignment of the top two vertebrae of the neck, this condition makes these individuals more prone to injury if they participate in activities which over extend or flex the neck. Parents are urged to have their child examined by a physician in order to determine whether or not their child should be restricted from sports and exercise activities which place stress on the neck. Although this misalignment is a potential serious condition, if properly diagnosed these individuals can be protected from serious injury.

Children with Down syndrome may have a tendency to become obese as they grow older. This weight gain has negative implications for the individuals' later health and longevity. A supervised diet and exercise program may help reduce this problem.

Older individuals with Down syndrome have been found to age prematurely. This aging process has become more apparent since the recent increase in the life span of individuals with the syndrome. There may be a connection between Down syndrome and the eventual appearances of Alzeheimer's disease, although further research needs to be done.

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Resources

Association for Retarded Citizens, United States
2501 Avenue J
Arlington, TX 76011
(817) 640-0204

Caring
P.O. Box 196
Milton, WA 98354
(206) 922-8194

National Down Syndrome Congress
1640 W. Roosevelt Road
Chicago, IL 60608
(312) 226-0416

National Down Syndrome Society
146 East 57th Street
New York, NY 10022
Hotline: (800) 221-4602
NY only: (212) 764-3070

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Epilepsy

Definition

According to the Epilepsy Foundation of America, epilepsy is a physical condition that occurs when there is a sudden, brief change in how the brain works. When brain cells are not working properly, a persons consciousness, movement, or actions may be altered for a short time. These physical changes are called epileptic seizures. Epilepsy is therefore sometimes called a seizure disorder. Epilepsy affects people in all nations and of all races.

Some people can experience a seizure and not have epilepsy. For example, many children have convulsions from fevers. These febrile convulsions are one type of seizure. Other types of seizures not classified as epilepsy include those caused by an imbalance of body fluids or chemicals or by alcohol or drug withdrawal. A single seizure does not mean the person has epilepsy.

Incidence

About 2.5 million Americans have epilepsy. Of the 100,000 new cases that develop each year, three quarters of them are in children and adolescents.

Characteristics

Although the symptoms listed below are not necessarily indicators of epilepsy, it is wise to consult a doctor if you or a member of your family experiences one or more of them:

- "Blackouts" or periods of confused memory;
- Episodes of staring or unexplained periods of unresponsiveness;
- Involuntary movements of arms and legs;
- "Fainting spells" with incontinence or followed by excessive fatigue;
- Odd sounds, distorted perceptions, episodic feelings of fear that cannot be explained.

Seizures can be generalized, meaning that all brain cells are involved. One type of generalized seizure consists of a convulsion with a complete loss of consciousness. Another type looks like a brief period of fixed staring.

Seizures are partial if the brain cells not working properly are limited to one part of the brain. Partial seizures may produce periods of automatic behaviour and altered consciousness.

Educational Implications

Epilepsy is defined as one of the potentially handicapping conditions in P.L. 94-142, The Education for All Handicapped Children Act. A student with epilepsy doesn't necessarily require a special education placement unless he or she also has some other special need such as a learning disability or mental retardation. In these instances, the epilepsy or related conditions may then interfere with the child's ability to learn.

If a child's physical or intellectural skills seem markedly altered since the seizures began, tell your doctor. There may be an associated hearing or perception problem caused by the brain changes. In addition, if a child has the type of seizure characterized by a brief period of fixed staring at school, he/she may be missing parts of what the teacher is saying. Ask your child's teacher to observe and document these episodes.

It's important that teachers understand about the child's condition, possible effects of medication, and what to do in case a seizure occurs at school. Most parents find that a friendly conversation with the teacher(s) at the beginning of the school year is the best way to handle the situation. Even if a child has seizures that are largely controlled by medication, it is still best to notify the school staff about the condition.

Children and youth with epilepsy must deal with the psychological and social aspects of the condition: this includes its lifelong nature, uncertain occurrence, loss of self control, and negative attitudes towards the condition.

School personnel and parents should work together to monitor the effectiveness of medication as well as any side effects. Their written observations will be helpful to the neurologist.

Individual decisions must be made regarding a child's participation in physical activities. It is important that both parents and teachers avoid overprotection. Teachers and classmates should also understand that, although children with epilepsy may have special needs, they are more like their classmates than different from them.

There are many materials available for parents and teachers, so that they can understand how to work most effectively together. The student will benefit the most when both teachers and parents are working together.

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Resources

Epilepsy Foundation of America
4351 Garden City Drive
Landover, MD 20785
(301) 459-3700

Epilepsy Information Line
University of Washington-Seattle
Toll Free Information Line:
(800) 426-0660

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Epilepsy Foundation of America Hotline:
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84

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Severe and/or Multiple Handicaps

Definition

The term severe handicap indicates an intense degree of a condition such as mental retardation, deafness, blindness, physical disability or emotional disturbance. It may also refer to more than one, or a "multiple" handicap, such as mental retardation and cerebral palsy or blindness and physical disability.

An individual with severe handicaps need not be multihandicapped. Severity describes the degree of involvement in a specific disability.

Incidence

For the 1983–84 school year, the states reported to the U.S. Department of Education that they were providing services to 65,537 children with multiple handicaps. This number represents .17% of the total school enrollment. Severe handicaps are not one of the categories reported.

Characteristics

Children and youth with severe or multihandicaps may exhibit a wide range of characteristics, depending upon the combination of handicaps, the child's age, and the severity of the disabilities. There are, however, some traits that these children may share, including:

- Limited speech or communication;
- Difficulty in basic physical mobility;
- Inability to care for themselves;
- Failure to relate to or attend to others; and
- Tendency toward self-injury or abuse

Medical Implications

Many different medical problems may accompany severe handicaps. A few examples include seizures, hydrocephalus, and scoliosis. These conditions should be taken into consideration when establishing services for the child. A multidisciplinary team consisting of the child's parents, educational specialists, and medical specialists in the areas in which the child demonstrates problems should work together to plan and coordinate the child's services.

Educational Implications

In the past, children with severe and/or multiple handicaps were regularly excluded from the public schools. Since the implementation of P.L. 94–142, the Education for All Handicapped Children Act, public schools are now serving large numbers of severely and/or multiply handicapped students. Some of these children and youths have returned from institutions, others may be entering structured programs for the first time, and still others are graduates of high quality intervention programs.

Educational programs for children with severe and/or multiple handicaps need to incorporate a variety of components to meet the children's tremendous needs. Thus instruction should cover the following areas:

- Academics;
- Communication;
- Sensory stimulation; and
- Self-Sufficiency

Related services are of great importance, and the multidisciplinary approach is crucial. Appropriate persons such as speech and language therapists, physical and occupational therapists, and medical specialists need to work closely with the classroom teacher and parents.

Frequently, classroom arrangements must take into consideration students' needs for medication, special diet, or special equipment. Special aids and adaptive equipment enable the children to increase their range of functioning. In recent years, for example, computers have become effective communication devices. Other aids which may be seen in classrooms include: wheelchairs, typewriters, headsticks (headgear), clamps, modified handles on cups and silverware, and communication boards.

Vocational and leisure skills are a critical consideration for children and youth with severe handicaps. Programming for maximum independence should begin as early as elementary school. To help in post-school adjustment and prepare the student for the greatest degree of independence and self-sufficiency, the program should draw on community services, including group homes, vocational programs, and recreational programs.

Integration with nonhandicapped students is another concern. For many of these students, placement in a special class of a local school allows for interaction during the normal school day.

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Resources

Accent on Information
P O Box 700
Gillum Road and High Drive
Bloomington, IN 61701

American National Standards Institute
1430 Broadway
New York, NY 10018
(212) 354-3300

American Coalition of Citizens with Disabilities
1346 Connecticut Avenue, NW
Washington, DC 20036
(202) 785-4265

Cancer Information Clearinghouse
National Cancer Institute
Bethesda MD 20205
(301) 496-4070

The Courtlighters Foundation
[illegible] I Street, NW - Suite 1011
[illegible]ington, DC 20006
([illegible]) [illegible]-5138

[illegible]n on Physically Handicapped
c/o The Council for Exceptional Children
[illegible] Association Drive
[illegible], VA 22091

Epilepsy Foundation of America
4351 Garden City Drive
Landover, MD 20785
(301) 459-3700

March of Dimes Birth Defects Foundation
P.O. Box 2000
1275 Mamaroneck Avenue
White Plains, NY 10605
(914) 428-7100

National Association of the Physically Handicapped
76 Elm Street
London, OH 43140
(614) 852-1664

National Easter Seal Society
2023 W. Ogden Avenue
Chicago, IL 60612
(312) 243-8400

National Library Service for the Blind and Physically Handicapped
Library of Congress
1291 Taylor Street, NW
Washington, DC 20542

National Rehabilitation Information Center
4407 Eighth Street, NW
Washington, DC 20017

United Cerebral Palsy Association
66 E. 34th Street
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Editor's Note:

This fact sheet provides information of a general nature. The references and resources provide numerous opportunities to seek more specific information about severe and/or multiple handicaps.

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This book presents practical suggestions for helping the severely handicapped child at school and at home. There is also a section on special equipment.

Featherstone, H. *A Difference in the Family: Life with a Disabled Child*. 1980. (Basic Books, Inc. 10 East 53rd Street, New York, NY 10022)
The author, educator and parent of a severely handicapped child, writes about parents' and siblings' feelings, marital stress, and both sides of the parent-professional partnership.

Finnie, N. R. *Handling the Young Cerebral Palsied Child at Home*. 1975. (E. P. Dutton, 2 Park Avenue, New York, NY 10016)
The book presents a practical approach (with illustrations) to feeding, dressing, and caring for the young child with cerebral palsy.

Freeman, R. D. and others. *Can't Your Child Hear? A Guide for Those Who Care About Deaf Children 1981*. (University Park Press, Baltimore, MD 21202)
Intended primarily for parents, the guide focuses on total communication as a way of life for deaf children.

Holland, E. *Let's Try to Help: A Guide for Parents of Young Multihandicapped Children*. 1976. (Oak Hill School, Connecticut Institute for the Blind, 120 Holcomb Street, Hartford, CT 06112)
Practical teaching methods and activities for parents of blind children with one or more additional handicaps.

Murray, J. B., and Murray, E. *And Say What He Is: The Life of a Special Child*. 1975. (MIT Press, 28 Carleton Street, Cambridge, MA 02142)
Parents of a severely handicapped child describe their encounters with the medical profession, educators, relatives, and friends.

Scott, E. P. and others. *Can't Your Child See?* 1977. (University Park Press, Baltimore, MD 21202)
Written for parents of visually handicapped children, the book includes a section on the needs of multiple handicapped blind children.

Education:

Jegard, S., and others. *A Comprehensive Program for Multihandicapped Children: An Illustrated Approach*. 1980. National Institute on Mental Retardation, Kinsmen NIMR Building, York University, 4700 Keele Street, Downsview, Ontario, M3J 1P3.
The book is designed for parents, teachers and child-care workers involved with multihandicapped and mentally retarded children. The text presents suggestions for developmental activities.

Sailor, W., Wilcox, B., and Brown, L. (Eds.) *Methods of Instruction with Severely Handicapped Students*. 1980. (Paul H. Brookes Publishers, P.O. Box 10624, Baltimore, MD 21204)
This book offers guidelines for the education of students with severe disabilities.

Van Etten, G., Arkell, C., and Etten, C. *The Severely and Profoundly Handicapped. Program, Methods, and Materials*. 1980. (C.V. Mosby Company, 11830 Westline Industrial Drive, St. Louis, MO 63141)
Sections on diagnosis, curriculum, materials and equipment are included in this text on education considerations.

Walsh, S. R., and Holzberg, R., (Eds.) *Understanding and Educating the Deaf/Blind Severely and Profound Handicapped*. 1979. (Charles C. Thomas Publishers, 2600 S. First Street, Springfield, IL 62717)
Fifteen authors contributed papers that focus on evaluation, programming and international education of deaf-blind severely and profoundly handicapped students

Other:

Blacher, J. *Severely Handicapped Young Children and Their Families Research in Review*. 1984. (Academic Press, Inc., Orlando, Florida 32887)
This book incorporates research conducted with families and educators reflecting the progress of the last decades to improve all aspects of teaching severely handicapped children.

Recources

Cerebral Palsy

United Cerebral Palsy Associations
66 East 34th Street
New York, NY 10016

With its affiliates 1) funds research; 2) advocates for the civil rights of disabled people; 3) provides education programs which emphasize prevention; and 4) provides direct services including medical services, special education, recreation, counseling and adapted housing.

Cornelia de Lange Syndrome

Cornelia De Lange Syndrome Foundation
60 Dyer Avenue
Collinsville, CT 06022

The organization is dedicated to parent/family support, education and research relating to individuals affected with CdLS. Publishes a newsletter Reaching Out and a CdLS Directory.

Deaf-Blind

National Association of Deaf-Blind
2703 Forest Oak Circle
Norman, OK 73071

Founded by parents to further educational, rehabilitation, and employment opportunities for deaf-blind people. Provides information and publishes a newsletter.

Deafness

Alexander Graham Bell Association
for the Deaf
3417 Volta Place, N.W.
Washington, DC 20007

Devoted to providing hearing impaired people with the opportunity to develop and use speech. Provides information and publishes a newsletter.

National Association of the Deaf
814 Thayer Avenue
Silver Spring, MD 20910

NAD recommends and promotes legislation on behalf of deaf people in areas of education, rehabilitation, legal rights for the provision of interpreters, hearing aid regulations, and captioned television.

Down Syndrome

Down Syndrome Congress
1640 West Roosevelt Road
Chicago, IL 60608

With more than 500 affiliates they provide: family support, factual information, bibliographies of materials relating to the disability, local referrals, identification of local resource, and 2 newsletters.

National Down Syndrome Society
146 E. 57th Street
New York, NY 10022

Promotes better understanding of Down Syndrome, the potential of persons with Down Syndrome, and research on the disability. New parent packets of information are available. Toll-free hotline 800-221-4602 NY only 212-764-3070.

Epilepsy

Epilepsy Foundation of America
4351 Garden City Drive
Landover, MD 20785

With over 100 affiliated Chapters and 60 local information and referral services, EFA is involved in advocacy and a wide variety of services and programs for the person with Epilepsy. Publishes a newsletter and other helpful information.

Hydrocephalus

Guardians of Hydrocephalus Research Foundation
2618 Avenue J
Brooklyn, NY 11235

Distributes literature on hydrocephalus. Operates a clinic in New York and runs five chapters in others parts of New York state.

Know Problems of Hydrocephalus
Route 1, Box 210A
River Road
Joliet, IL 60436

Is a parent group for families with children who have hydrocephalus.

Mental Retardation

Association for Retarded Citizens/US
Post Office Box 6109
2501 Avenue J
Arlington, TX 76011

With its state and local chapters, promotes better education, training, job opportunities, and housing for mentally retarded children and adults. Also publishes a newsletter.

Muscular Dystrophy

Muscular Dystrophy Association
810 Seventh Avenue
New York, NY 10019

Provides a full range of services for persons with various types of dystrophy.

Neurofibromatosis

National Neurofibromatosis Foundation
70 West 40th Street, 4th Floor
New York, NY 10018

Promotes public awareness, provides professional workshops, produces publications, and offers referral services.

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Mental Retardation

Definition

Persons with mental retardation are those who mature at a below average rate and experience unusual difficulty in learning and social adjustment. The American Association on Mental Deficiency (AAMD) provides the following technical definition, which is widely accepted.

"Mental Retardation refers to significantly subaverage general intellectual functioning in or associated with impairments in adaptive behavior and manifested during the development period."

Intellectual functioning is defined by a score on an IQ test. Persons with mental retardation usually score below 70, or in specific cases, based on new definition, below 75. Adaptive behavior refers to the person's adjustment to everyday life. Difficulties may occur in learning communication, social, academic and vocational skills. The amount of difficulty experienced will depend upon the person's age or development stage. The developmental period is from birth to age 22.

The AAMD definition does not mention prognosis or cause of mental retardation. Although there are more than 250 specific identified causes, in most cases the exact reasons for retardation are unknown.

Mental retardation is not a disease, nor should it be confused with mental illness. Mentally retarded children grow into mentally retarded adults; they do not remain "eternal children." The big difference is that they learn more slowly and with much greater difficulty.

Incidence

Depending upon the definition and measurement approach used, estimates of mentally retarded persons in the general population range from 1% (when relying on the adaptive behavior measurement) to 3% (when the IQ score is emphasized).

According to data reported to the U.S. Department of Education by the states, in the 1983-84 school year, 750,534 students with mental retardation were provided services by the public schools. This number represents 1.86% of the school enrollment.

About 89% persons with mental retardation are mildly retarded; about 6% are moderately retarded; and about 5% are severely or profoundly retarded.

Many authorities agree that individuals with mental retardation develop in the same way that nonretarded persons do, but at a slower rate, and reach a lower overall level of functioning. Others suggest that persons with retardation have difficulties in particular cognitive areas, such as attention, perception or memory. Depending on the extent of the retardation—mild, moderate, severe, or profound—individuals will develop differently in academics, social, and vocational skills.

Mildly retarded persons are in many respects quite similar to their nonretarded peers. While still young their retardation is not readily apparent. Moderately retarded persons are more obviously handicapped, and their retardation is usually apparent before school age. Severely or profoundly retarded persons have obvious intellectual impairments and frequently have other handicaps such as cerebral palsy, epilepsy, blindness, or deafness.

Appropriate educational opportunities beginning in infancy and continuing throughout the development period will allow retarded children to develop to their fullest potential. They can enter the competitive labor market and the mainstream of daily life. Persons with retardation can learn to care for their basic needs and can perform useful work with supervision.

Educational Implications

Persons with mental retardation have the capacity to learn, to develop, to grow. The great majority of retarded persons can become productive and full participants in society. As with all education, individualization is the starting point for successful learning. Throughout their child's education, parents should be an integral part of the planning and teaching team.

In teaching persons with retardation, it is important to:

- Use concrete materials,
- Proceed in small sequential steps and to review each step frequently,
- Provide prompt and consistent feedback, and
- Stress the child's success.

Simple everyday tasks that nonretarded persons learn without instruction need to be structured and specifically taught to persons with retardation. Similarly, tasks should be presented so that the students are able to apply what they have learned to other situations. Special care should be taken to obtain and hold the students' attention.

Children and adults with retardation need the same basic services that other human beings need for normal development. These include education, vocational preparation, health services, recreational opportunities, and many more. In addition, many persons with retardation need specialized services to meet extraordinary needs. Such services include diagnostic and evaluation centers, special early education opportunities beginning with infant stimulation and continuing through preschool, additional day training after completing school with an emphasis on independent living and vocational skills, sheltered employment, assistance in obtaining full employment, and community living opportunities.

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Speech and Language Impairments

Definitions

Speech and language impairments refer to problems in communication. Examples include fluency problems (called dysfluency or commonly, "stuttering"), articulation problems, voice disorders, and aphasia (a difficulty using words, usually as a result of brain injury).

The development of speech and/or language may be delayed due to many factors, including environment or hearing loss. Sometimes speech or language impairments may result from other conditions, such as learning disabilities, mental retardation, and cerebral palsy.

Prevalence

Five percent of school aged children are estimated to have speech and language disorders. The number of students identified with delayed speech decreases steadily as children mature.

Characteristics

A child with delayed communication is noticeably behind his or her agemates. Frequently a child will have greater receptive (understanding) than expressive (speaking) language skills. In that case, children may be able to follow directions but have problems producing comprehensible speech or correct syntax and articulation. (Syntax refers to the order of words in a sentence, articulation refers to how sounds are formed. Articulation disorders are characterized by substituting one sound for another such as "wabbit" for "rabbit," by omitting sounds such as saying "han" for "hand," or by distortions such as saying "thay" for "say".)

Students whose primary language is different from standard English may have difficulty communicating in the majority language.

Stuttering, a disorder of speech flow, most often appears between ages 3 and 4 and may progress from a periodic to a chronic problem. Although many children who stutter recover by puberty or early adolescence, speech and language therapy should be considered.

Physical problems, such as cleft lip or palate, may result in difficulties with certain sounds or with control of the voice quality. Articulation problems, a very common form of speech disorder, result in omissions, substitutions, or distortions of sounds.

Typical voice disorders include hoarseness, breathiness, or sudden breaks in loudness or pitch. Frequently, voice disorders are combined with other speech problems to form a complex communication disorder.

Educational Implications

Language experiences are central to a young child's development. Because they introduce and interpret the world to their children via language, parents play a crucial role in stimulating interest and skills with words.

Speech and language therapists function in a support role for teachers of children with communication handicaps. Sometimes therapists remove a child from the class for individual speech therapy, although many therapists now consult with teachers about the best ways to help the child in the regular class setting. The same kinds of helpful techniques may be shared with the parents, so the improvement approach is consistent at home and at school.

Many speech and language "problems" are part of a child's normal development in learning to talk. They become problems when the child is seriously behind his or her same age friends. If you are concerned about a child's speech or language, consult a speech and language therapist. In all cases, it is important to remember that children with speech and language impairment are more like their classmates than different from them.

Technology can help children whose physical conditions make communication difficult. The use of electronic communication devices allows even severely physically disabled people to engage in the give and take of shared thought.

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Berthal, J.E., and Bankson, N.W. *Articulation Disorders*. 1981. (Prentice-Hall Inc., Englewood Cliffs, NJ 07632)

Bloodstein, O. *A Handbook on Stuttering*. 1975. (Easter Seal Society, 2023 W. Ogden Avenue, Chicago, IL 60612)

Prader Willi Syndrome

Prader Willi Syndrome
5515 Malibu Drive
Edina, MN 55436

The association shares knowledge and experience about the syndrome and how to manage it. Publishes a newsletter and other helpful information.

Scoliosis

National Scoliosis Foundation
48 Stone Road
Belmont, MA 02178

Provides educational information including audio-visual materials available for grades 5 through 9.

Scoliosis Association, Inc.
1 Penn Plaza
Suite 3300
New York, NY 10119

Provides education of the general public, sponsors screening programs in schools, and publishes a screening manual for school health personnel.

Spina Bifida

Spina Bifida Association of America
343 South Dearborn Street
Suite 319
Chicago, IL 60604

Emphasizes local parent support groups, of which there are approximately 100 in the U.S. and Canada. Publishes manuals and booklets for parents and teachers.

Tourette Syndrome

Tourette Syndrome Association
Bell Plaza Building
41–02 Bell Boulevard
Bayside, NY 11361

Maintains a clearinghouse of information on Tourette Syndrome. Publishes newsletter and other helpful information.

Tuberous Sclerosis

National Tuberous Sclerosis Association, Inc.
Post Office Box 159
Laguna Beach, CA 92652

Brochures, pamphlets for parents, reprints of articles, fact sheets and genetics of Tuberous Sclerosis are available. Publishes a newsletter and maintains a speakers bureau.

Other Helpful Organizations:

ABLEDATA
National Rehabilitation Information Center
4407 Eighth Street, N.E.
The Catholic University America
Washington, DC 20017-2299

Provides information on adaptive equipment and other rehabilitation aids.

Council for Exceptional Children
1920 Association Drive
Reston, VA 22091

Is a membership organization dedicated to advancing the education of exceptional children and youth. Produces publications on special education topics and also conducts computer searches of the literature.

March of Dimes Birth Defects Foundation
1275 Mamaroneck Avenue
White Plains, NY 10605

Supports medical research, sponsors medical services and community services, and act as an information clearinghouse.

National Easter Seal Society
2023 West Ogden Avenue
Chicago, IL 60612

In addition to producing a large number of publications on disabilities, sponsors clinics, research, and workshops.

SKIP (Sick Kids [Need] Involved People)
216 Newport Drive
Severna Park, MD 21146

Serves as a support, resource and educational group to help families to plan a smooth transition from hospital to home for children with various levels of physical instability.

The Association for the Severely Handicapped (TASH)
7010 Roosevelt Way, N.E.
Seattle, WA 98115

Is a membership organization including educators, therapists, researchers, doctors, parents, and others concerned with severely handicapped children and adults. Publishes newsletter, journals, and books.

Trace Research and Development Center for the Severely Communicatively Handicapped
University of Wisconsin-Madison
314 Waisman Center
1500 Highland Avenue
Madison, WI 53706

Has list of publications concerning computers and other communication devices.

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Visual Impairments

Definitions

The terms "legally blind", "partially sighted", and "low vision" may mean different things in legal and educational contexts. The educational definitions of the terms are given below:

- Visual handicap indicates that some type of visual problem has resulted in a need for special education.
- Blindness refers to a condition with no vision or only minimal vision (light perception). Blind students learn via Braille or other non-visual media.
- Low vision refers to limited distance vision. People with low vision are able to see items close to them. They use a combination of vision and other senses to learn, although they may require adaptations in the lighting or size of print.

Visual impairments can include myopia, hyperopia, and astigmatism; problems in the visual field; and muscular problems that result in visual disturbances.

Incidence

The rate at which visual impairments occur in the general population increases considerably with age, especially after 65. For individuals under 45, the estimated incidence is 7 per 1,000; for individuals over 65, it is 44.5 per 1,000.

Characteristics

The effect of visual problems on a child's development depends on the severity, type of loss, age at which the condition appeared, and overall functioning level of the child. The child may be delayed in motor, cognitive, and/or social development.

A young child with visual handicaps has little reason to explore interesting objects in the environment, and thus may miss opportunities to have experiences and to learn. This lack of exploration may continue until hearing becomes motivating or until intervention begins.

Because the child cannot see parents or peers, he or she may be unable to imitate social behavior or understand nonverbal cues. Visual handicaps can create obstacles to a growing child's independence.

Educational Implications

The student with visual impairments should be tested early in order to assess remaining vision. Mainstreaming has been a successful way of serving the academically oriented student with visual handicaps. These students may need additional help with special equipment and modifications in the regular curriculum to emphasize listening skills, communication, orientation and mobility, vocation/

Hixon, T.J., Shribers, L.D., and Saxman, J.H. (Eds.) *Introduction to Communication Disorders*. 1980. (Prentice-Hall, Inc., Englewood Cliffs, NJ 07632

Shames, G.H. and Wiig, E.H. *Human Communication Disorders. An Introduction*. 1982. (Charles E. Merrill Publishing Co., Columbus, OH 43216)

Van Hattum, R.J. *Communication Disorders. An Introduction*. 1980. (Macmillan Publishing Company, Inc., 866 Third Avenue, New York, NY 10022)

Wiig, E.H. *Language Disabilities in Children and Adolescents*. 1976. (Charles E. Merrill Publishing Co., Columbus, OH 43216)

Wiig, E.H. *Talkabout: Developing Prosocial Communication Skills*. 1982. (Charles E. Merrill Publishing Co., Columbus, OH 43216)

Resources

American Cleft Palate Educational Foundation
Parent Liaison Committee
Louisiana State University Medical Center
Department of Audiology and Speech Pathology
3735 Blair
Shreveport, LA 71103

American Speech Language and Hearing Association
10801 Rockville Pike
Rockville, MD 20852

Association for Children and Adults with Learning Disabilities
4156 Library Road
Pittsburgh, PA 15234

Division for Children with Communication Disorders
c/o The Council for Exceptional Children
1920 Association Drive
Reston, VA 22091

National Easter Seal Society
2023 West Ogden Avenue
Chicago, IL 60612

National Institute of Nerological and Communicative Disorders and Stroke
National Institutes of Health, HHS
Building 31, Room 8A—06
Bethesda, MD 20205

Prescription Parents (Cleft Lip/Palate)
P. O. Box 426
Quincy, MA 02269

Trade Research and Development Center for the Severely Communicatively Handicapped
314 Waisman Center
1500 Highland Avenue
Madison, WI 53706

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career, and daily living skills. Students with low or limited vision may need help in using their residual vision more efficiently and in working with special aids and materials. Students who have visual handicaps combined with other types of handicaps may have greater need for an interdisciplinary approach and may require greater emphasis on self care and daily living skills. It is important that all members of the school team and parents understand the child's physical capabilities and limitations. To promote growth, parents and teachers should avoid overprotection and encourage children to take risks within the limits of safety and health. Teachers and classmates should also understand that, although children with visual impairments and children who are blind are handicapped, they are more like their classmates than different from them.

References

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Buell, Charles. *Physical Education for Blind Children*. 1983. (Charles C Thomas Publisher, 2600 South First Street, Springfield, IL 62717)

Cleary, Margaret. *Please Know Me As I Am, A Guide to Help Children Understand Children With Special Needs*. 1975. (Exceptional Parent Press)

Corn, A., & Martinez, I. *When You Have a Visually Handicapped Child in Your Classroom: Suggestions For Teachers*. 1983. (The American Foundation for the Blind, 15 W. 16th Street, New York, NY 10011)

Ferrell, Kay A. *Parenting Preschoolers: Suggestions for Raising Young Blind and Visually Impaired Children*. 1984. (The American Foundation for the Blind, 15 W. 16th Street, New York, NY 10011)

Kamien, Janet. *What If You Couldn't—A Book About Special Needs*. 1979. Contains classroom unit on blindness. (Charles Scribner and Sons, 115 5th Ave., New York, NY 10003)

Kastein, S., Spaulding, I. & Scarf, B. *Raising the Young Blind Child. A Guide for Parents and Educators*. 1980. (Human Sciences Press, Inc., 72 Fifth Avenue, New York, NY 10011)

Kelley, Jerry. *Recreation Programming For Visually Impaired Children and Youth*. 1981. (The American Foundation for the Blind, 15 West 16th Street, New York, NY 10011)

Krents, Harold. *To Race The Wind*. The film, "Butterflies Are Free" is based on this young man's account of growing up blind. 1974. (G.P. Putnam and Sons, 200 Madison Ave., New York, NY 10016)

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Nelson, Roberta. *Creating Community Acceptance for Handicapped People*. 1978. (Charles C Thomas, Publisher, 2600 So. First St., Springfield, IL 62717)

Nousanen, D., & Robinson, L.W. *Take Charge! A Guide to Resources for Parents of the Visually Impaired*. 1980. (The National Association for Parents of the Visually Impaired, 2011 Hardy Circle, Austin, TX 78575)

Schuch, J. *Get Ready, Get Set, Go! A Guide for Parents of Visually Impaired Children*. 1975. (International Institute for Visually Impaired, Rutgers, East Lansing, MI 48823)

Stratton, Josephine. *The Blind Child in the Regular Kindergarten*. 1977. (Charles C. Thomas, Publisher, 2600 So. First St., Springfield, IL 62717)

When You have A Visually Handicapped Child In Your Classroom: Suggestions for Teachers by Teachers. 1977. (American Foundation for the Blind, 15 West 16th Street, New York, NY 10011)

Willoughby, D. A. *Resource Guide for Parents and Educators of Blind Children*. 1979. (National Federation of the Blind, 1800 Johnson Street, Baltimore, MD 21230)

Yeadon, A., & Grayson, D. *Living with Impaired Vision: An Introduction*. 1979. (The American Foundation for the Blind, Inc., 15 West 16th Street, New York, NY 10011)

Tannenbaum, Robin. *A Different Way of Seeing*. 1983. (The American Foundation of the Blind, Inc., 15 West 16th Street, New York, NY 10011)

Resources

American Association of Workers for the Blind
206 North Washington Street
Alexandria, VA 22314

American Council for the Blind
1211 Connecticut Avenue, N.W.
Washington, DC 20036
(800) 424-8666 toll free
(202) 833-1251

American Foundation of the Blind
15 West 16th Street
New York, NY 10011
(212) 620-2000

American Printing House for the Blind
1800 Frankfort Avenue
Louisville, KY 40206
(502) 895-2405

Association for Education of the Visually Handicapped, Inc.
206 N. Washington Street
Alexandria, VA 22314
(703) 836-6060

Division for the Visually Handicapped
c/o The Council for Exceptional Children
1920 Association Drive
Reston, VA 22091
(703) [illegible]3660

International Institute for Visually Impaired, 0–7, Inc.
1975 Rutgers Circle
East Lansing, MI 48823
(517) 351-6300
or
14 Gay Street
Newtonville, MA 02160
(617) 527-0476

National Association for Parents of the Visually Impaired, Inc.
2011 Hardy Circle
Austin, TX 78757

National Association for the Visually Handicapped
305 East 24th Street, 17-C
New York, NY 10010
(212) 889-3141

National Eye Institute
National Institutes of Health
Building 31, Room 6A32
Bethesda, MD 20205
(301) 496-5248

National Federation of the Blind
1800 Johnson Street
Baltimore, MD 21230
(301) 659-9314

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AUTISM

Definition

According to the National Society for Children and Adults with Autism (NSAC), autism is a severely incapacitating developmental disability that usually appears during the first three years of life.

Prevalence

The rate of prevalence, or how often autism occurs in children, ranges from five to fifteen out of 10,000 births. The different estimates are based on slightly different definitions of autism.

It is four times more common in boys than girls and is rarely found in more than one child in a family.

There appear to be several causes of autism, each with distinct neurological effects. Among these causes are untreated phenylketonuria, rubella, celiac disease, and chemical exposures in pregnancy. No known factors in the psychological environment of a child have been shown to cause autism.

Characteristics

Sometimes infants show autistic behaviors from birth; they appear aloof, resist cuddling and show no interest in their surroundings. Children usually have average appearances. Typical characteristics include:

- absent or delayed speech and language, including immature speech rhythms, limited understanding, and use of words without attaching usual meanings.
- abnormal ways of relating to people, objects, and events
- unusually high or low activity levels
- insistence that the environment and routine remain unchanged
- use of toys and objects in unconventional manners
- slow development or lack of physical, social, and learning skills
- repetitive movements such as rocking and spinning, head banging, and hand twisting.

It should be noted that these characteristics may occur in children with other disabilities. Sometimes the term "autistic-like" behavior is used.

Educational Implications

Early diagnosis of autism is very important, but appropriate help given at any age can make a big difference.

The child or youth with autism appears to profit from a high degree of structure in the educational program. Such programs frequently stress social and language skills, with instruction broken down into small, sequential steps.

Although the majority of children with autism are severely delayed in learning, most can learn academic skills and social functioning in an appropriate program.

Many parents and teachers have found that behavior modification can assist the child in developing appropriate behavior.

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Wing, L. (Ed.) Early Childhood Autism. 1976. (Pergamon Press, Inc., Maxwell House, Fairview Park, Elmsford, NY 10523)

Resources

Institute for Child Behavior Research
4157 Adams Avenue
San Diego, CA 92116

National Clearinghouse for Mental Health Information
National Institute of Mental Health, HHS
15C-17 Parklawn Building
5600 Fishers Lane
Rockville, MD 20857

National Society for Children and Adults with Autism
1234 Massachusetts Avenue, NW
Suite 1017
Washington, DC 20005-4599

NSAC Bookstore
1234 Massachusetts Avenue, N.W.
Suite 1017
Washington, DC 20005-4599

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97

DEAF-BLIND AND MULTIHANDICAPPED CURRICULUM

Developmental Activities For Primary Aged Children

FINE MOTOR ACTIVITIES

1. **Parquetry Blocks** These are wooden blocks of various shapes and colors that can fit together to make different designs. The designs may be produced by the student or they may be copied from a design that the teacher has prepared. These blocks also help to develop visual discrimination of size, shape, and color.
2. **Modeling Clay** Modeling clay has a wide degree of applicability. It helps to develop the tactile-kinesthetic clues necessary for communicative skills.
3. **Chothespins** There are a number of good activities that can be developed using clothespins. One activity might be to have the child place the clothespins on a string. A second activity would be to have the child drop the clothespins in a bottle. Both activities are designed to improve fine motor movements and eye-hand coordination.
4. **Gloves** Putting on and taking off gloves (not mittens) requires finger dexterity.
5. **Bean Bag Toss** Tossing bean bags can be an excellent way to teach a child to judge distances at the same time that a motor exercise is being practiced. The distance of the target can be varied so that the child receives practice in throwing the bean bag to a near and far point.
6. **Rubber Horseshoes** Throwing horseshoes will serve the same purpose as the bean bag toss but can be used as an alternate.
7. **Going Fishing** Cut out fish from colored construction paper. Put a staple in each fish. Then tie a small magnet on a string to a pencil or stick. Let the child go fishing for a colored fish of his choosing. To add flavor to the game, the teacher might ask the child to guess what color fish he will get. This game is excellent for teaching color discrimination, depth perception, and eye-hand coordination.
8. **Artificial Fruit** (1) Identify objects from a grab bag. (2) Identify fruit by shape and texture.
9. **Sewing Cards** These cards are very appealing to the primary elementary school child. The cards should provide pictures of familiar objects and geometric figures to be outlined by the child with yarn or shoestrings.
10. **Rhythm Band** Many of the rhythm instruments provide practice in fine coordination as well as practice in the memory of motor patterns.
11. **Dressing a Doll** Dressing and undressing a doll gives the child an opportunity to work with buttons and button holes, zippers, and snaps and to manipulate small objects.
12. **Paper Folding** There are a number of goods books on the market that provide a variety of paper folding activities.
13. **Paper Weaving** Cut strips of paper approximately one inch wide and twelve inches long. Show the child how to weave the strips to form a pattern. Begin with only two colors.
14. **Embroidery Set** There are very simple embroidery sets manufactured that can be enjoyed by the primary age child. Manipulation of the needle and threat helps to develop fine motor skills.
15. **YoYo** Although the child should use the yoyo in his dominant hand, he should be given some practice in fine motor coordination with his non-dominant hand.
16. **Cutting** Start with a very simple exercise such as cutting fringe from a piece of paper; next, cut curved lines and angles. Then progress to a combination of these. The use of scissors should be stressed in systematic steps. Use left-handed scissors for a left-handed child.
17. **Placing and Pasting** Let the children experiment with placing different shapes on paper in the appropriate outline. When they have been placed correctly, they should be pasted in position.
18. **Tracing and Coloring** Tracing and coloring should begin with simple shapes and large objects. As the child progresses, the shapes could be made more complex.
19. **Finger Tracing** This could be used for a young child whose fine motor coordination is immature. Let the child trace everything with his finger before making an attempt to do so with his pencil. Air tracing and tracing with the feet are both good exercises for added reinforcement.
10. **Pegboard Designs** The child should copy the design going from left to right. To begin with, the child should utilize designs that employ only one color. More difficult designs may consist of many colors.

21. **Finger Painting** This activity provides the child with tactile-kinesthetic clues. Finger paints could be used to reinforce the motor patterns for letters or numbers.

22. **Jack and Ball** This activity involves eye-hand coordination, fine motor skills, sequencing memory and timing of motor movements.

23. **Sorting Boxes** You could use buttons, spools, lids, plastic shapes, hair rollers, small medicine bottles, nails, etc. The articles may be sorted by color, shape, category,texture, etc.

24. **Sorting Colors** Make colored dominoes without spots. Use two-inch squares cut from construction paper. Mount them on cardboard strips 2" by 4". The child matches these color by color.

25. **Puzzles** There are many different puzzles that you can make, such as:
    A. Mount a face on a cardboard. Cut it into two or three pieces. Have the child assemble the pieces.
    B. Mount the picture of a bottle and cut it in half vertically. Have the child place the parts in correct position.
    C. Animals can be mounted on cardboard for the child to place the parts together.
    D. Different shapes can be cut and the child places them in correct position.
    E. Pictures out of magazines can be mounted and cut. The child matches the parts together.
    F. Letters can be mounted and cut into pieces. Begin first by cutting the letters in halves. The child must put the pieces together so the letter is formed.
    G. Make a puzzle from a photograph of the child.

26. **Drawing** A child can draw by reproducing patterns from dot-to-dot or by number-to-number. Picture completion exercises are good also. Coloring the completed drawings gives added practice in fine motor coordination.

27. **Chalkboard Exercises** (A) The Clock Game--On the chalkboard draw a large circle with points so that number 1 and 5 are vertical lines, 7 and 3 are horizontal lines, 6 and 2 and 8 and 4 are diagonal lines. In the center should be a square box labeled 0. This is the goal for all movements. The child should place his left hand on one number and his right hand on another. He is then told to move his right hand to a called number and his left hand to a called number. Both hands move at the same time and arrive at their goals at the same time. (B) This could be used with opposite movement also. The child could practice movements away from the center, parallel movements, crossed meridian movements. etc.

28. **Tearing Paper Designs** The child is given a sheet of paper and is instructed to tear a shape, letter or design, depending on the child's individual ability.

29. **Paper Mache Beads** This is a good exercise for finger dexterity. Cut from heavy slick magazine pages, wedge shaped pieces of paper of uniform size, usually about 4 inches long and 1 inch wide at the wide end. Then, roll the wedges, staring with the wide end on a nail and paste securely. Slip nail out and dry. String these on heavy threat, ribbon, etc.

30. **Everyday Activities** Fine motor coordination is needed in everyday life, such as buttoning and unbuttoning, lacing shoes, opening and closing snaps and zippers, tying strings, putting on socks and taking them off, using simple tools and carrying objects. These activities should be practices by all children who have difficulty in fine motor coordination.

31. **Statue Squares**, circles, and triangles are placed on the floor and the child may only step on the circles as he winds his way through the maze. By adding music to the activity, the game becomes "Statue" with the children freezing when the needle is lifted from there cord.

32. **Discrimination Game** Place four children with a number of similar physical characteristics in front of the room and select another child from the class to be "it". The child who is "it" is to pick, as soon as he is able from your clues, the child of whom you are thinking. While the game is in progress, the remainder of the children will silently play the game too.

33. **Incomplete Pictures** The children would fill in the missing parts; have them identify pictures of objects that would normally be be found indoors or outdoors,or have them group objects such as rocks into classifications such as rough, sharp,or spotted.

34. **Discrimination of Symbols** Show the child a line and ask him to select a line exactly like it from a series of lines, some of which are shorter or longer and some of which are indifferent positions. Beyond this point the developmental lessons include the selection of letters of the alphabet. For example, the child is to select the b, or any other letter from a number of letters on a line.

35. **Discrimination of Combinations of Letters** In a row of groups of letters, which might include gab, bga, abg, and bag, he can look for abg. This finer visual discrimination leads to the ability to locate such words as dog in a row of words. More complex words are introduced, and ultimately three rows of words can be used for discrimination practice. Thus we have a basis for a successful reading program.

36. **Beads for Stringing** Use different shapes, sizes, and colors. Make a design for the child to follow.

37. **Sorting Boxes** Use shapes, spools, nails, buttons, marbles.

38. **Color Bingo** Teaches color and number identification. Can be made or purchases.

39. **Concentration** Make word cards, picture cards, or color cards and place them face down. The child tries to match the two cards that are alike.

40. **Parquetry Blocks** Child copies a design card.

41. **Picture Dominoes** Dominoes with pictures on one side and colors on the other.

42. **Spell by Pictures** Pictures are manipulated until three identical pictures are lined up and the correct spelling is found at the bottom.

43. **Bingo with ABC** A bingo game, where children learn their ABC's.Spinner dial shows twenty-four objects that are matched on cards along with letters.

44. **Old Maid** Matching pictures.

45. **Match-Ums** Match 30 pictures to 30 words. Can be purchased or made.

46. **Authors** A card game. Players match and collect books of similar cards.

47. **Symbols** This game is similar to dominoes. Colored symbols are used instead of dots. The same device may be used to show differences in symbols and may be varied in degree of complexity from three to six or more symbols in a row.

48. **Letter Game** The children are given sheets prepared with short rows of lower case letters and capital letters. The children are to circle the large letters or the small letters, depending on the pattern that is given.

49. **Seeing and Drawing** The teacher draws on the blackboard a large symbol. the child looks at it for ten seconds and then draws it on his paper without looking at the board.

30. **Work Sheets** Make a sheet with five rows of pictures on it. In each row make one of the pictures different. The child is instructed to circle the one that is different in each row.

GROSS-MOTOR ACTIVITIES

1. Walking on a balance board or chalk line.
2. Duck Walk.
3. Skipping, hopping on one foot-then the other, forward and backward.
4. Catching and throwing a large ball.
5. Climbing
6. Jumping from different positions and over small obstacles.
7. Stretching and bending exercises.
8. Calisthenics.

Most of the above named activities can be conducted at home with one child or a small group. Any child could benefit from repetition of these activities which lead to maturational development.

SONGS

1. "I have a friend his name is (**child says his name**)."

Middle C C C C C E G EC

I have a friend his name is _____.

C C C C C E G EC

I have a friend his name is _____.

D D D D D B D BG

and _____ is a **boy** (child says)

C GF E D C

and he is four years old. (child's part)

C G F E D C

2. "Good morning to you **name,** _____, _____,

G AG F E CEE

Good morning to you _____

"What can you do today?"

G G G G C

(The child performs and all copy his action to a rhythmic background with the same music - i.e. children clap hands and adults sing ta dum, ta dum, for 15 beats).

3. (Tune: London Bridges)

"I am special, yes I am.

Yes I am, yes I am,

I am special, yes I am.

I am special.

No one's eyes are just like mine,

Just like mine, just like mine,

No one's eyes are just like mine,

I am special."

4. (Tune: Paw - Paw Patch)

"Where, oh where is pretty little Peggy,

Where, oh where is pretty little Peggy,

Where , oh where is pretty little Peggy,

(child is to stand)

Right over there in her chair."

5. (Tune: Thumbkin)

Group-"Where is _____ (child's name) ?

Where is _____?

(child stands)

Here I am.

Group-How are you today Miss/Sir _____,

How are you today Miss/Sir _____,

Please sit down, please sit down."

6. "_____ (child's name) has new shoes,

_____ has new shoes,

_____ has new shoes,

_____ has new shoes all day long."

(Insert different item for each child)

7. (Tune: Ha Ha This-A-Way)

(The child stands in the middle and shifts his weight

from left to right foot in rhythm).

"When I was a little girl/boy,

When I was a little _____,

When I was a little _____, ____ years old."

(All children around the circle with hands joined singing along and shifting their weight from one foot to the other to this verse).

"Ha Ha this a way,

7. Continued

Ha Ha that a way,

Ha Ha this a way,

_____ years old.

(child then picks next child).

8. (Tune: Mulberry Bush__

(Group: is in a circle - teacher and one child walk around the outside)

"Here we go walking all around, all around, all around,

Here we go walking all around,

Now tell us your name when we stop."

(walking, skipping, hopping, etc.)

(Choose the next child who gives name before exchanging places to go

around with the teacher next).

9. "I have a good friend, a good friend, a good friend,

I have a good friend and _____ is his name."

(Child chooses next friend to be in the center of the circle)

10. (Children in a circle - teacher chooses 1st child)

"I have a friend who you all know and _____ is his name.

I have a friend who you all know and _____ is his name.

Get on board little children,

Get on board little children,

There's room for many more."

(Child gets behind teacher beginning a train - Child picks next child etc. until all are in the train line going around the circle singing).

11. Tune: Dinah)

(One child is in the circle with an instrument.)

"No one's in the circle with _____ (child's name).

No one's in the circle I know ooooh,

11. Continued

No one's in the circle with _____,

Playing on the instrument just so."

(Teacher gives instrument to the child to play when all have sung the last line.)

12. "Today is _____ (say the day),

Today is _____,

Let's meet name, and all (child picks action) today."

(everyone imitates)

13. (Leader takes one child into the center of the circle.)

"Here comes _____,

Here comes _____,

Here comes _____, all the way here.

(give action - strut, skip, hop, walk)

"Strut Miss/Sir _____, strut Mis/Sir _____, strut

Miss/Sir _____, strut all the way home."

(Child goes back to place in circle.)

14. "Brand new shoes, brand new shoes,

C G E A F D

Name has some brand new shoes.

AG F D A G E

(Child shows that his new shoes can run, hop, skip, jump, walk, etc.)

They can _____, they can _____, name new shoes can action."

C G E A F D GG G A B C

Brand new shoes, pretty little hands, etc.)

15 (Tune: Punchinello)

"What can you do child's name, child's name,

15. Continued

What can you do _____ _____ today.

(child does action)

We'll do it too child's name,child's name,

We'll do it too and have fun like you."

(all imitate action)

16. (Tune: Hi Ho, Hi Ho)

"My friend,my friend, my very special friend,

He likes to come and play with me my very special friend.

My friend, my friend, my very special friend,

He has a drum he likes to play, Boom, Boom - Boom Boom."

(Use different instruments and have the child play in the center with the others imitating the sound.

SELF-HELP/DAILY LIVING SKILLS

	Most appropriate for CA				
	0-3	4-6	7-9	10-12	13+
Reg. Class	X	X			
Lrng Hdcp	X	X			
Comm Hdcp	X	X			
Phys Hdcp	X	X	X	X	X
Sev Hdcp	X	X	X	X	X

#1204

title: FEEDING AND EATING

type: Instructional Sequence

Instructions

Student _____

1.0 Open mouth when physically stimulated by spoon held by another.	2.0 Opens mouth voluntarily at the sight of food.	3.0 Removes semi-li food from spoon with mouth when being fed some rejection.
6.0 Removes semi-solid food from spoon with mouth when being fed--some rejection.	7.0 Removes semi-solid food from spoon with lips when being fed--some rejection.	8.0 Retains all sem solid and semi-liqui from spoon without s drooling.
11.0 Eats pieces of finger food when offered by adult.	12.0 Holds finger foods.	13.0 Grasps finger f offered by adult and ries them to mouth.
16.0 Separates finger foods by mouth--bites off pieces.	17.0 Carries finger foods to mouth and bites off smaller pieces.	18.0 Swallows one bi finger food before more to mouth.
21.0 Grasps spoon in fist.	22.0 Rubs spoon across plate and licks spoon.	23.0 Chews and swall semi-solid food. J tion begins.

DEVELOPED BY: (Adapted from Santa Cruz County's BCP's)

B C P's

Behavioral Characteristics Progression

organized as

THE **STEP** SYSTEM

Sequential **T**asks for **E**ducational **P**lanning

CAJON VALLEY UNION SCHOOL DISTRICT

Special Education Department

quid --	4.0 Removes semi-liquid food from spoon with lips when being fed--some rejection.	5.0 Allows spoon to be removed from mouth.
i- d food pitting.	9.0 Moves food in mouth with tongue.	10.0 Squeezes, smears pieces of finger food.
oods car-	14.0 Reaches for finger foods and carries them to mouth.	15.0 Separates finger foods by hand--pulls off pieces.
te of dding	19.0 Bites off appropriate size pieces of finger foods using teeth.	20.0 Reaches for spoon when being fed.
ows w mo-	24.0 Chews and swallows pieces of finger food. Chews in rotary motion.	25.0 Brings fist-held spoon to mouth. Inserts spoon.

DATE DEVELOPED: 1/78

Title: FEEDING AND EATING

#1204

#1204	title: FEEDING AND EATING	
26.0 Fills fist-held spoon.	27.0 Fills fist-held spoon, inserts spoon in mouth, turns spoon in mouth.	28.0 Fills fist-he spoon and inserts s mouth without turni
31.0 Uses spoon held in fingers with precision: separates large-sized foods, eats liquids.	32.0 Directs spoon held in fingers to mouth--some spilling.	33.0 Eats holding fist with spilling.
36.0 Directs fork held in fingers to mouth--some spilling.	37.0 Directs food on spoon or fork into mouth without dropping any on way to mouth.	38.0 Fills spoon o with one mouthful o at a time.
41.0 Uses spoon for liquids and semi-solids; uses fork for solids.	42.0 Serves self at table.	43.0 Spreads with e.g., butter, jam.
46.0 Prepares foods for eating, e.g., peels banana, cracks hard-boiled egg, etc.	47.0 Opens containers. Removes foods. Unwraps foods, e.g., opens lunch pail.	48.0 Carries own t through serving lin
51.0	52.0	53.0

THE **STEP** SYSTEM

CAJON VALLEY UNION SCHOOL DISTRICT
Special Education Department

STUDENT NAME:

ld poon in ng.	29.0 Eats, holding spoon in fist--some spilling.	30.0 Eats, holding spoon in fingers with more than one finger independent of palm and palm up.
fork in	34.0 Eats holding fork in fingers in standard position--some spilling.	35.0 Uses fork held in fingers with precision: separates foods, dips into foods, spears foods.
r fork f food	39.0 Swallows food in mouth before taking another bite.	40.0 Chews food thoroughly before swallowing.
knife,	44.0 Cuts with knife.	45.0 Cuts with knife and fork.
ray e.	49.0 Serves self in cafeteria.	50.0 Manages to eat different types of foods: liquids, crisp foods, slippery foods.
	54.0	55.0

#1204

	Most appropriate for CA				
	0-3	4-6	7-9	10-12	13+
Reg. Class					
Lrng Hdcp					
Comm Hdcp					
Phys Hdcp	X	X	X		
Sev Hdcp	X	X	X	X	X

#1307

title: PUTTING ON T-SHIRT

type: Mastery of a Single Behavior

Instructions

1. Adapted from The Teaching Research Curriculum Moderately and Severely Handicapped by H. D. B Fredericks et al, 1977.
2. Prompts for each objective apply only to new of behavior, not previously mastered response(

Student _____

1.0 Puts on T-shirt when both arms are through sleeves with full physical prompt.	2.0 Puts on T-shirt when both arms are through sleeves with light physical prompt.	3.0 Puts on T-shi both arms are thro sleeves with verba
6.0 Puts on T-shirt when one arm is through, other arm is halfway through with light physical prompt.	7.0 Puts on T-shirt when one arm is through, other arm is halfway through with verbal prompt.	8.0 Puts on T-shi one arm is through arm is halfway thr prompt.
11.0 Puts on T-shirt when one arm is through, other hand to opening with verbal prompt.	12.0 Puts on T-shirt when one arm is through, other hand to opening, no prompt.	13.0 Puts on T-shi one arm is through with full physical
16.0 Puts on T-shirt when one arm is through sleeve, no prompt.	17.0 Puts on T-shirt when over head, one hand to sleeve opening with full physical prompt.	18.0 Puts on T-shi over head, one han opening with light prompt.
21.0 Puts on T-shirt when placed over head with full physical prompt.	22.0 Puts on T-shirt when placed over head with light physical prompt.	23.0 Puts on T-shi placed over head w prompt.

DEVELOPED BY: Kathi Teague

B C P's

Behavioral Characteristics Progression

organized as

THE **STEP** SYSTEM

Sequential **T**asks for **E**ducational **P**lanning

CAJON VALLEY UNION SCHOOL DISTRICT

Special Education Department

rt when ugh l prompt.	4.0 Puts on T-shirt when both arms are through sleeves, no prompt.	5.0 Puts on T-shirt when one arm is through, other arm is halfway through with full physical prompt.
rt when , other ough, no	9.0 Puts on T-shirt when one arm is through, other hand to opening with full physical prompt.	10.0 Puts on T-shirt when one arm is through, other hand to opening with light physical prompt.
rt when sleeve prompt.	14.0 Puts on T-shirt when one arm is through sleeve with light physical prompt.	15.0 Puts on T-shirt when one arm is through sleeve with verbal prompt.
rt when d to sleeve physical	19.0 Puts on T-shirt when over head, one hand to sleeve opening with verbal prompt	20.0 Puts on T-shirt when over head, one hand to sleeve opening, no prompt.
rt when ith verbal	24.0 Puts on T-shirt when placed over head, no prompt.	25.0 Puts on T-shirt when placed on lap in correct position with full physical prompt.

Title: PUTTING ON T-SHIRT

#1307

DATE DEVELOPED: 2/78

Suggested Criterion: 80% Success

#1307	title: PUTTING ON T-SHIRT	
26.0 Puts on T-shirt when placed on lap in correct position with light physical prompt.	27.0 Puts on T-shirt when placed on lap in correct position with verbal prompt.	28.0 Puts … placed on … position, …
31.0 Puts on T-shirt when placed on lap with verbal prompt.	32.0 Puts on T-shirt when placed on lap, no prompt.	33.0
36.0	37.0	38.0
41.0	42.0	43.0
46.0	47.0	48.0
51.0	52.0	53.0

on T-shirt when lap in correct no prompt.	29.0 Puts on T-shirt when placed on lap with full physical prompt.	30.0 Puts on T-shirt when placed on lap with light physical prompt.
	34.0	35.0
	39.0	40.0
	44.0	45.0
	49.0	50.0
	54.0	55.0

	Most appropriate for CA 0-3	4-6	7-9	10-12	13+
Reg. Class	X				
Lrng Ndcp		X			
Comm Ndcp		X			
Phys Ndcp	X	X			
Sev Ndcp	X	X	X	X	X

#1103

title: ADVANCED TOILETING

type: Curriculum Milestones

Instructions

Student _____

1.0 Maintains dry diapers or pants for at least two hours.	2.0 Moves bowels one or two times each day at generally the same times.	3.0 Indicates b action, vocaliza wet and/or soile
6.0 Uses toilet immediately after placed.	7.0 Tears toilet tissue as directed.	8.0 Attempts wip needs help.
11.0 Adjusts clothing before leaving bathroom (zips, buttons, etc.)	12.0 Indicates by gesture, action, vocalization need to go to toilet.	13.0 Goes to, sit stands near toil endently.
16.0 Goes to toilet when necessary with infrequent accidents.	17.0 Goes to toilet properly by self with no accidents.	18.0 Asks location room in new situa
21.0	22.0	23.0

99

DEVELOPED BY: (Adapted from Santa Cruz County's BCP's)

B C P's

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CAJON VALLEY UNION SCHOOL DISTRICT

Special Education Department

...y gesture, ...tion when ...d.	4.0 Sits on toilet when placed and supervised.	5.0 Sits on toilet when left alone.
...ing but	9.0 Flushes toilet as directed.	10.0 Washes and dries hands. Disposes of towel if necessary.
...on, or ...t indep-	14.0 Flushes toilet, uses toilet tissue when necessary.	15.0 Goes to toilet at regular intervals without asking e.g., after recess.
...of bath- ...tion.	19.0 Obtains help with any toileting problem.	20.0 Attends to toilet needs without help.
	24.0	25.0

Title: ADVANCED TOILETING

#1103

DATE DEVELOPED: 11/77

Summary of Skills

COMMUNICATION AND THE PARAPROFESSIONAL

COMMUNICATION

Communication is the process whereby there is a transfer of meaning between people. It involves sending and receiving messages. Words in themselves have no meaning; only persons have meaning. Communication is sending the message that I am, to you and receiving the message that you are.

Four "C's" for Clear Communication

CAUTION: Approach all communication situations cautiously. Think through all details before confronting the topic.

COURAGE: Conflicts are not solves by avoidance. don't let anxiety prevent you from approaching the topic.

CONFIDENCE: Have enough confidence in yourself to be assured that you can communicate effectively. If a situation has caused you concern; it is worth pursuing.

COMPREHENSION: Be concise. Present yourself clearly. Be sure you understand.

Communication can be the most important asset to a good working relationship.

Bonnie D. Kramer
Paraprofessional Facilitator
Atchison-Jefferson Special Education Coop
Oskaloosa, KS 66066

THE DIRTY DOZEN

ROAD BLOCKS WHICH HALT EFFECTIVE COMMUNICATION

1) DIRECTING, COMMANDING, ORDERING ("You must . . . ," "You have to . . . ," "You will . . . . ,")

Such responses can produce fright or active resistance and rebellion. Nobody likes to be ordered or commanded--thus resentment is produced. Such responses may cut off further communication from the client. Often they will feed rejected--their own needs are being ignored.

2) WARNING, THREATENING, ADMONISHING ("You had better . . . ," "If you don't, then . . .")

Such responses are like directing or ordering except that the response brings in the threat of power. As with directing and ordering, these responses may produce resentment, anger, resistance and rebellion.

3) MORALIZING, PREACHING, OBLIGING ("You should . . . ,"You ought . . . ," "It is your duty . . . ," "It is your responsibility . . . ," "You are required . . . "

Such responses are like directing and ordering except that this response drags in "duty" and some vague external authority. The purpose is to make the client feel guilty or to feel an obligation. Clients sense the pressure of such messages and frequently resist and dig in their heels. Such messages also communicate lack of trust--"You are not wise enough." Clients often respond with "Who says I should" or "Why should I?"

4) PERSUADING WITH LOGIC, ARGUING, INSTRUCTING, LECTURING ("Do you realize . . .," "Here is why you are wrong . . . ," "That is not right . . . ," "The facts are . . . ," "Yes, but . . . ,")

Such responses provoke defensiveness and often bring on counter arguments. They may also make the client feel inferior because they imply the helper's superiority. Persuasion, more often than not, simply makes the client defend their own position more strongly. Having logic on your side does not always bring forth compliance or agreement. Who is able to be logical while being upset.

5) ADVISING, RECOMMENDING, PROVIDING ANSWERS OR SOLUTIONS ("What I would do is . . . ," "Why don't you . . . ," "Let me suggest . . . ," "It would be best for you . . . ,") with it rather than thinking up their own solutions. Advise can also make clients dependent; it does not encourage their own creative thinking. A client may simple respond my feeling the helper just doesn't understand--"How could you suggest that, you don't know how scared I am". Also, if the helper's advice turns out wrong, the client can duck responsibility--"They suggested it; it wasn't my idea."

6) EVALUATING, JUDGING, NEGATIVELY, DISAPPROVING, BLAMING, NAME-CALLING, CRITICIZING ("You are bad," "You are lazy," "you are not thinking straight," "You are acting foolishly," "Your hair is too long.")

More than any other type of message, this makes clients feel inadequate, inferior, incompetent, bad or stupid. It can make them feel guilty, too. Evaluation cuts off communication--"I won't tell them what I feel if I am going to get judged."

7) PRAISING, JUDGING OR EVALUATING POSITIVELY, APPROVING ("You're a good boy," "You've done a good job," "That's a very good drawing," "I approve of . . . ," "That's a nice thing to do.")

Helpers often send these messages to clients without understanding they can have negative effects. To reassure a client may make him feel that you don't understand--"It is easy for you to say that, but you don't know how sacred I am." Supporting messages can also convey to the client "I'm not comfortable having you feel inadequate. I can't accept such feelings; start feeling more adequate." If things do not "turn out all right" for the client, then he can feel resentful toward you for your reassurances, for misleading them.

9) DIAGNOSING, PSYCHOANALYZING, INTERPRETING, READING-IN, OFFERING INSIGHTS ("What you need is . . . ," "What's wrong with you is . . . ," "You're just trying to get attention . . . ," "You don't really mean that," "I know what you need," "Your problem is . . . ,") likely, will stop communication from the client rather than encourage them to tell you more.

10) QUESTIONING, PROBING, CROSS-EXAMINING, PRYING, INTERROGATING ("Why . . . ," "Where . . . ," "What . . . ," "Who . . . ," "How . . . ," "When . . . ,")

The response of clients to probing, is often to feel defensive or "on the witness stand." Many questions are threatening because the client doesn't know why the helper is questing them--"What are you driving at?" Clients may feel the helper is "nosey". Questioning can convey lack of trust, suspicion or doubt about the client's ability. When helpers ask question, they imply that they are gathering information so that they can solve the client's problem rather than let the client solve it for themselves. Questions drastically restrict the range of what clients might say if allowed to speak spontaneously. They communicate "Talk only about what I am asking."

11) DIVERTING, AVOIDING, BY-PASSING, DIGRESSING, SHIFTING ("Let's not talk about it now," "Forget it," "That reminds me," "We can discuss it later.")

Such responses make clients feel you are not interested. They may feel you don't want to understand. Clients may also feel guilty. They communicate lack of respect of the client. Such responses can make a client feel rejected.

12) KIDDING, TEASING, MAKING LIGHT OF, JOKING, USING SARCASM ("When did you read a newspaper last," "Get up on the wrong side of the bed?")

Such responses effectively cut off communication, make the client feel you are not interested and show lack of respect. They often will make the client angry. Or a client may feel you really don't understand how badly or seriously they feel about something. Responses such as these often stem from hostility in the helper, consequently, they may provoke counter-hostility

TEN COMMANDMENTS FOR GOOD LISTENING

1) STOP TALKING.
   You cannot listen if you are talking.
   Polonius (Hamlet): "Give every man thine ear, but a few thy voice."

2) PUT THE TALKER AT EAST.
   Help him feel that hi is free to talk.
   This is often called a permissive environment.

3) SHOW HIM THAT YOU WANT TO LISTEN.
   Look and act interested. Do not read your mail while he talks.
   Listen to understand rather than to oppose.

4) REMOVE DISTRACTIONS.
   Don't doodle, tap, or shuffle papers.
   Will it be quieter if you shut the door?

5) EMPATHIZE WITH HIM.
   Try to put yourself in his place so that you can see his point of view.

6) BE PATIENT.
   Allow plenty of time. Do not interrupt him.
   Don't start for the door or walk away.

7) HOLD YOUR TEMPER.
   Allow plenty of time. Do not interrupt him.
   Don't start for the door or walk away.

8) GO EASY ON ARGUMENT AND CRITICISM.
   This puts him on the defensive. He may "clam up" or get angry.
   Do not argue: even if you win you lose.

9) ASK QUESTIONS.
   This encourages him and shows you are listening
   It helps to develop points further.

10) STOP TALKING!
    This is first and last, because all other commandments depend on it.
    You just can't do a good listening job while you are talking.

GROUPS OF FEELINGS - NEGATIVE

1) ALONE, left out, unwelcome,lonely, apart, neglected, severed.

2) ANGRY, furious, resentful, fuming, seething, hostile, hateful indignant, injured.

3) BAD, naughty, worthless,inferior.

4) BORED, disinterested.

5) BOTHERED, pestered, annoyed, troubled.

6) BURDENSOME, endured, put up with, tolerated,in the way appeased.

7) COLD, lukewarm, part, callous, indifferent.

8) CONFUSED, mixed up, unreasonable.

9) DEAD, numb, dull.

10) DISAPPOINTED, let down.

11) DEFEATED, discouraged, failing, weak, resigned, submissive, over-powered,conquered.

12) DISGUSTED, repelled, immoral, repugnant.

13) DISINTERESTED, indifferent, bored,unconcerned.

14) EMBARASSED, mortified, shamed, ashamed.

15) FRIGHTENED, scared, afraid,horrified, cautious, terrified, fearful.

16) FRUSTRATED, trapped, cornered, caged,censored, appeased, discouraged.

17) JEALOUS, envious.

18) INFERIOR, inadequate, unworthy.

19) INSECURE, unloved, uncared for,unwanted, unwelcome.

20) GUILT, sad, grief-stricken.

21) INADEQUATE, unworthy, worthless, incapable.

24) LEFT OUT, unwanted, unloved, rejected, abandoned.

25) MANIPULATED, managed, used, placated, maneuvered, imposed upon, exploited.

26) PUT-DOWN, censored, subdued.

27) RESISTANCE, resentment, fighting, stubborn,subversive, restrained, held back, negative, obtuse, with-drawn.

28) SAD, unhappy, dejected, melancholic, grief-stricken, let-down, depressed.

29) RESTLESS, uneasy,nervous, tense.

30) SENSITIVE

31) SHOCKED, numb, shaken, stunned, dead, paralyzed, immobilized.

32) PASSIVE

33) PUT-UPON, overworked, pick on on,pressured.

34) SUSCEPTIBLE, vulnerable, weak,helpless, threatened, tormented.

35) STIFLED

36) TIRED, weary, exhausted.

37) UNCOMFORTABLE, uneasy, at a loss, fidgety, ill at ease, restless.

38) UPSET, troubled, bothered, restless, agitated, shaken, uptight, frantic, emotional, hysterical,irritated,unbalanced,disturbed, wild, perturbed, annoyed, appeased, fussed, distressed, worried.

39) UNFEELING, uncaring, uncared for, unloved, undemonstrative.

40) LOVED, unwanted, uncared,for unacceptable, rejected, abandoned.

41) WILD, impetuous, frantic, hysterical, out of control

GROUPS OF FEELINGS - POSITIVE

1) ADMIRED, looked up to, important, respected.

2) ATTRACTIVE, lovely, beautiful, admired.

3) ALIVE, vibrant, bubbly, animated, effervescent, buoyant, invigorated, vivacious.

4) APPRECIATIVE, fortunate, lucky, thankful, grateful.

5) ACCEPTING, acceptance, receptive, responsive.

6) BEAUTIFUL, attractive, handsome.

7) CONFIDENT, adequate, competent, capable.

8) CORDIAL, welcomed, friendly, warmed, hospitable.

9) CONCERNED, care.

10) CALM, at peace, satisfied, peaceful, composed, comfortable, tranquil, serene, quiet, safe, sustained.

11) COMFORTABLE, cozy warm, at peace.

12) DELIGHTED, enchanted, bewitched, amused, captivated, excited.

13) ENLIGHTENED, enriched, fulfilled.

14) EXCITED, enthusiastic, eager, elated, ecstatic, animated, thrilled, stimulated, anxious.

15) FEMININE, beautiful, needed, loved, wanted, cared for, desirable, seductive, vibrant.

16) FREE, unencumbered, childlike, expressive, out-going.

17) INTERESTED, stimulated, fascinated.

18) INSPIRED, impressed, uplifted, transported, enlightened, ful-filled.

19) LOVED, cared for, loving, affectionate, supported, accepted, secure, trusted, safe, wanted, protected, enamored, considered.

20) HAPPY, pleased, joyful, jubilant, delighted, enchanted, cheerful, delirious, ecstatic, intoxicated, transported, contented.

23) OPTIMISTIC, outgoing, gregarious, enthusiastic, hopeful.

24) POSITIVE, sure, right.

25) RICH, prosperous, successful.

26) REFRESHED, renewed, revitalized.

27) RECEPTIVE, responsive.

28) ROMANTIC, sentimental, thoughtful.

29) SATISFIED, pleased,proud, triumphant.

30) SYMPATHETIC, pity, empathetic, tactful.

31) SENSITIVE, tenderness

32) SINCERE, in earnest

33) SURPRISED, amazed, astonished, flabbergasted.

34) SUPPORTED, sustained, encouraged.

35) TALENTED, gifted, purposeful, product, intelligent, poised, successful.

36) TRUSTED, accepted, loved.

37) UNDERSTOOD, cared for, loved.

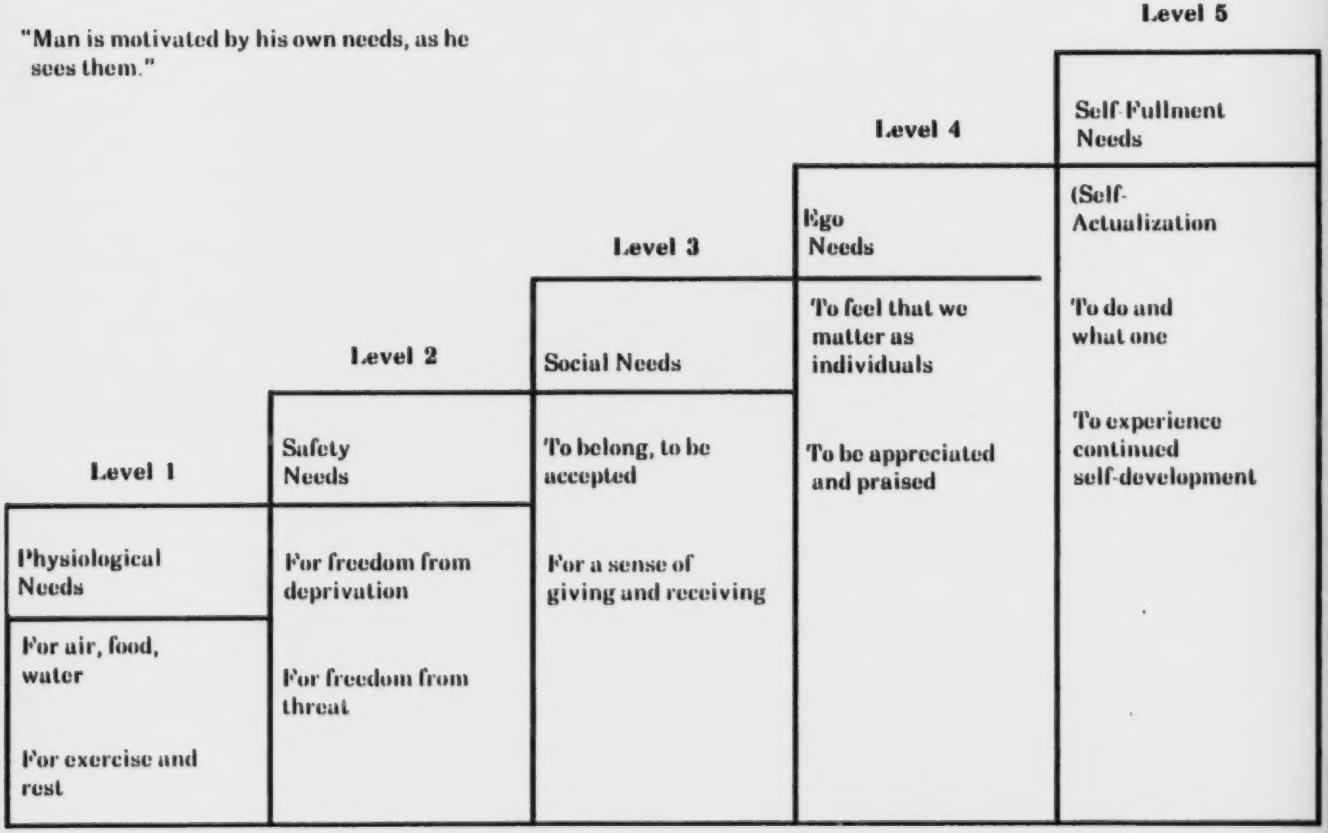
38) VICTORIOUS, triumphant.

39) WORTHY, deserving, wanted.

40) WANTED, considered, cared for, loved, wanted, included.

MASLOW'S HIERARCHY OF NEEDS

"Man is motivated by his own needs, as he sees them."



FACILITATIVE COMMUNICATION "LEADS"

Phrases that are useful, when you trust that perceptions are accurate, and the helpee is receptive to your communications:

You feel . . .
From your point of view . . .
In your experience . . .
From where you stand . . .
As you see it . . .
You think . . .
You believe . . .
What I hear you saying . . .
You're . . .(identifying the feeling, i.e., angry, sad, overjoyed)
I'm picking up that you . . .
I really hear you saying that . . .
Where you're coming from . . .
You figure . . .
You mean . . .

Phrases that are useful when you are having some difficulty perceiving clearly, or it seems that the helpee might not be receptive to your communications:

Could it be that . . .
I wonder if . . .
I'm not sure if I'm with you but . . .
Would you buy this idea . . .
What I guess I'm hearing is . . .
Correct me if I'm wrong, but . . .
Is it possible that . . .
Does it sound reasonable that you . . .d
Could this be what's going on, you . . .
From where I stand you . . .
This is what I think I hear you saying . . .
You appear to be feeling . . .
I appears you . . .
Perhaps you're feeling . . .
I somehow sense that maybe you feel . . .
Is there any chance that you . . .
Maybe you feel . . .
Is it conceivable that . . .
Maybe I'm out to lunch, but . . .
Do you feel a little . . .
Maybe this is a longshot, but . . .
I'm not sure if I'm with you, do you mean . . .
I'm not certain I understand: you're feeling . . .
It seems that you . . .
As I hear it, you . . .

HELP!!! WHAT DO I SAY NOW? I"M STUCK!"
(Key Phrases and Statements)

"HOW DO I START?"

"Something happened today."
"It's pretty hard to talk about."
"I'd like to listen, if you want to talk about it."
"I'd like to hear about it."

"SHE/HE'S CLAMMED UP!"

"If you decide that you'd like to talk later, I'd like to listen." or
"I'll be here."
"If you want to talk about it, I'm here."
"I'd like to be trusted."

I'M CONFUSED"

"I'd like to help you, but I don't know what is going on."
"I'm trying to understand, but I'm having trouble."
"I don't understand."
"Let me check." (recap what has been said)
"I still don't understand what is going on."
"I'd like to help you, but I don't know how."
"I don't feel that I have all the facts"
"Something is going on, I don't understand and I'd like to."

SHE/HE'S CONFUSED"

"You're confused."
"Then it isn't (original problem) you are worried about (you don't like; afraid of etc.)
It is _____."
"Part of you wants to _____ and part of you wants to _____"
"You don't understand." OR "You don't understand _____"

"SHE/HE'S STUCK, IS AVOIDING OR CIRCLING"

"You are confused."
"It is hard to talk about."
"You're uncomfortable (sad, feel bad, are hurt etc.) about this."
"It is kind of embarrassing to talk about."
"I'd like to help you, but I don't know how."
, don't have the facts."
, don't understand."

SOLUTION ORIENTED) "HELP! WE'RE READY FOR A SOLUTION, BUT HOW DO WE ARRIVE AT IT?

"You are looking for some ways to straighten this out."
"You are looking for some ways to make it right."
"Can you think of something that might work?"
OR "Could we think of some ways together? What can you think of?"
"You want to figure some way to work this through."

"What do you think you can do about this?"
"What do you think you can do about this?"
"You want some help with this. Let's see what we can think of together: got any ideas?" (if can't come up with ideas,then develop several choices and let him choose one.)
"You want to straighten this out, but you don't know how."
"I get the idea that you'd like to work this out somehow. Got any ideas?"
"Would you like to practice talking to Mrs. Jones with me? Shall I be Mrs. Jones or you?" (This is a good chance to model something that might work for him and that may be acceptable.)
"If I were Mrs. Black I would understand if you came and said"
"If I were Mrs. Black I would like to know how you felt."
"You don't like any solution you see. Can we think of some more."
"You want to straighten it out,but it is going to be hard."

(MIDDLEMAN) "SHE/HE'S TRYING TO DUMP HIS PROBLEM ON ME AND I DON'T WANT IT."

"I'm not willing to."
"I feel that is between you and _____."
"I don't feel that I am involved."
"I am not willing to become involved,because it does not concern me."

COMMUNICATION IS BLOCKED, NOW WHAT?"

"I'd like to be trusted."
"I'd like to help."
"If you want to talk about it later,I would like to listen."
"I seemed to have said something that has come between us. I don't want that to happen."

(AFTER A STRONG "I" MESSAGE) SHE/HE'S COMPLETELY SILENT OR IMMOBILIZED'

"I feel that I've hit you pretty hard. I'd like to hear your side."
"I'd like to hear your side of this."
"Perhaps I have been unfair, because I am pretty angry but,"

BEHAVIOR MANAGEMENT

TIPS ON GUIDING CHILDREN'S BEHAVIOR

These are a few tips taken from the philosophy that is practiced at the Povl Toussieng Early Childhood Development Center.

1. USE A CHILD'S NAME to give attention and recognition for appropriate behavior and to acknowledge or greet the child in a positive way. AVOID using the child's name when misbehavior occurs or when correcting a child.

Children make connections between their names and the behaviors they exhibit. When we connect their names with good behaviors we can expect the best. On the other hand, when we use their names in relation to misbehaviors we can expect them to misbehave.

Help build the child's self esteem and positive self image by using the name only with appropriate behavior and in supportive ways. A child whose entire name is called should be excited with anticipation of having done something wonderful in the eyes of the adult. After all, a name is the child's hallmark.

2. HELP CHILD LEARN WHAT TO DO instead of what not to do. Children respond quickest to statements of WHAT TO DO. The brain processes ACTION verbs and the body reacts accordingly.

AVOID using "don't" phrases because the child responds first to the action verb and the "what." For example, when you say, "Don't splash the water, " the child's brain process "SPLASH the water." The child learns what to do when you say,"Pour the water gently, " "Walk way around the puddle," "Be gentle with your sister." "Use your quiet voice" is better than "Don't shout."

3. GIVE ATTENTION TO THE VICTIM FIRST. When a child gets hurt, pushed or displaced, go to that child and give tender care before attending the aggressor. This helps children know that you will look out for their well being. Then turn to the aggressor and, without using his or her name, give help in what to do.

4. MODEL THE BEHAVIORS YOU EXPECT. Children learn to behave by watching others; they learn to speak by hearing others; they form relationships by interacting with others. Setting examples may be the most powerful influence they will experience in learning.

Wanda Draper, Ph.D. 1987

IDEAS THAT MAY HELP YOU HANDLE PROBLEMS

1. Discuss with your teacher what problems you may have to handle, how she wishes you to handle them, and how you would feel comfortable handling them. Devise a system that works for the two of you. Some the following ideas may be helpful.

2. Carry out classroom rules even when the teacher must leave the room and you are in charge.

3. When a child does misbehave, stay calm. Don't yell; speak firmly and confidently. Use a fairly low pitched voice--no shrill shriek. Don't "put on a show".

4. Tell the child what he did that was wrong and what he should have done or repeat the classroom covering offense.

Example: "You hit Chris. We don't hit in this class."
"You threw toys. During play time we play with toys. We don't throw them."

5. Watch your choice of words very carefully. You must get across the idea that you still like the child but you do not like what he has done. You can tell him how his actions have made you feel but you must never, never tear down his character.

Statements such as these get your message across but preserve the child's dignity (and yours!)

"When you yell at me like that, it makes me mad and hurts my feelings."

"I really like you but I don't like it when you throw toys at Clifford. You make me very mad when you do that."

Statements such as these are cruel, emotionally abusive and have no place at all in the classroom.

"You're just a bad boy, that's all!"
"You just hit people all the time!"
"You'll just never learn, will you?"
"Why can't you learn it? Are you stupid or something?"

6. Never let yourself get into an "I didn't do that--Yes, you did" argument with a child.

7. It's often a good idea to move the misbehaving child away from the group to a position where you can still see him but where he can't see the other children. Once you have moved him, don't let him talk you into letting him come back. Keep him out about five minutes and if he is calm, you bring him back to the group. If he repeats the offense, then calmly and firmly remove him again. In really extreme cases you might keep a child out of the group for 7 to 10 minutes but not more than ten. The offending child will get fidgety and bored and you will get more problems than you had in the first place. Use a timer if you can't remember to keep track of the time.

If you have a child who likes to be by himself away from the group, do not use this technique with him. It is likely to increase his misbehavior since he may misbehave in order to be moved away from the group.

8. Don't threaten a child with a punishment particularly in front of the class. Many children will take it as a challenge.

Instead of:

"If you do that one more time, you will have to sit by yourself"

try taking the child aside and saying something like:

"You have been having trouble remembering not to hit your friends. We don't hit in this class. People who hit have to leave the group until they can control themselves."

9. When the children have done something right, tell them. When they do what you ask them to do, tell them how proud you are of them. When a child stops an offensive behavior compliment him. Make it a point to compliment each child at least four times each day. Do it even when you have to find something to compliment on. If behavior is really a problem find a one minute period when he is not hitting, talking, etc. and compliment him them.

10. Never tell a child you will do something you know you will not really do. Don't bluff. Some child will call you on it.

MANAGEMENT IDEAS THAT MAY HELP PREVENT MISBEHAVIOR

1. Keep each child busy with constructive activities on his own developmental level. Be aware that each child will need different activities; and will need them changed often to avoid boredom.

2. Keep apart those children who tend to set each other off and become behavior problems.

3. Children who just quietly don't participate are management problems too. Don't forget about them and let them sit. You must help them get involved in classroom activities.

Watch particularly for the physically handicapped child who can use neither his hands nor his legs and the blind or severely visually impaired child. These children may need lots of adult help and encouragement in addition to adaptive toys and switching equipment.

4. Place children so the adults in charge can touch or get to each child quickly and easily. Let your eyes sweep the group. Make eye contact, smile and say something to each child every few minutes. Remember visually impaired children won't see you looking at them and deaf and hard-of-hearing children may not hear you speak.

MOTOR DEVELOPMENT OF DEAF-BLIND AND MULTIHANDICAPPED CHILDREN

BODY MECHANICS

BODY CARE IS IMPORTANT BECAUSE:

1. The quality of your life depends on it.
2. Your job depends on it.

RISK FACTORS

1. Poor Posture
2. Poor Physical Condition
3. Overweight
4. Fatigue
5. Increases Stress
6. Hurried
7. Overambitious
8. Carelessness
9. Poor Body Mechanics

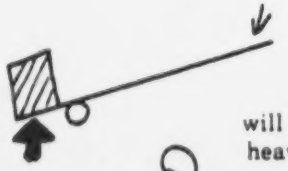
YOUR BACK IS VULNERABLE

Even though you think you are getting away without hurting your back using poor lifting techniques, you may not be. Disc fibers can be torn over a period of years without your even knowing it.

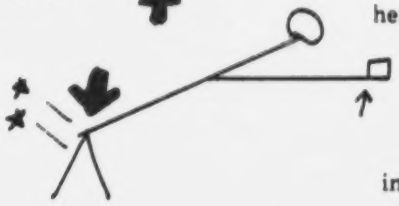
BASICS OF BODY MECHANICS IN LIFTING

1. Good posture
2. Appropriate clothing
3. Broad base of support
4. Bend knees - Use your legs!
5. Avoid reaching
7. Turn with feet - Don't twist back (This goes for pushing and pulling too)
7. Use step stood - Don't lift above shoulders

Levers can work for you - or against you.



Using a long lever, only a little push will lift something heavy



However, lifting a little weight puts a tremendous stress in low back

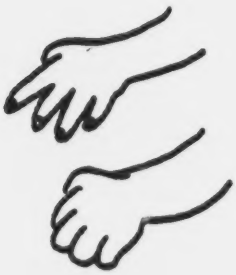
BASICS OF GOOD BACK CARE IN PATIENT LIFTING

1. Use basic body mechanics-Apply to all situations
2. Plan your lift, know your patient.
3. Communicate with other staff and your patient.
4. Get help if needed.

DEVELOPMENT OF GRASP (Prehension)

1.

Reflexive grasp with ulnar side fingers (#3, 4, & 5) being used. There is no thumb or index finger involvement.

2 

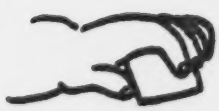
Raking and primitive squeezing involves all fingers but not the thumb. Fingers are wide spread and all the way open, followed by all closed.

3.

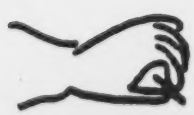
Whole hand grasp (radial-palmar) uses all fingers to hold object. Thumb may begin to press against the side of the toy as it it grasped or being held.

4

Lateral pincer grasp (radial-digital) involves the thumb pressing against the side of the hand or index finger.

5 

Three point pinch (palmar, 3 jaw chuck) involves the thumb, index and middle finger. Used 70% of the time throughout life.

6 

Pincer grasp involves tips of thumb and index finger. The wrist is extended or raised up slightly.

ADAPTED EQUIPMENT FOR FEEDING AND EATING

RUBBER SPOON - Designed to protect teeth and lips. We recommend these for clients who have problems with servere bite reflex.

COATED SPOON - The bowl of the spoon is coated with strong nylon coating for protection of the teeth. We recommend this spoon for clients who have problems with reflex bite.

CURVED HANDLED SPOON - Designed for use with clients who have limited wrist flexibility.

WEIGHTED UTENSIL - (8 oz. additional weight in the handle) Recommended for clients who display poor coordination or jerky movements in performing the sequence of patterns required for feeding ones self.

SPORK - A combination spoon/fork. Recommended for some clients who are unable to handle a fork but are able to function a little more independently in their eating skills with this combination utensil. Also recommended for clients who may be having a difficult time with the transition from spoon to fork.

BUILT UP HANDLE UTENSIL - These are available in various forms. 1) Soft removable tubing. 2) Built up permanent handle is recommend for clients with poor grip.

VERTICAL PALM OR HORIZONTAL PALM UTENSIL - These utensils are designed for use by clients who may have fixed or limited wrist movement and poor grip.

ELASTIC STRAP CUFF - Designed so a regular handled utensil may be inserted into the pocket of the cuff. Recommended for clients who have the pattern sequence for eating but are unable to hold utensil.

ONE-HANDED ROLLERKNIFE - Designed for clients who have 1) Use of only one hand 2) Weakness 3) Lack of two/handed coordination.

ROCKER KNIFE - Designed to be used with a rocking motion. Recommended for clients who have 1) Use of only one hand 2) Weakness 3) Lack of two/handed coordination.

Plates and other special equipment designed to assist with clients who are messy eaters or have poor coordination or spastisty

TRIANGULAR SUCTION PLATE - Three suction cups to hold place in place.

SCOOP PLATES - High on one side to assist with getting food on the spoon.

FOOD GUARD - Designed to be placed on a regular place or triangular suction plate.

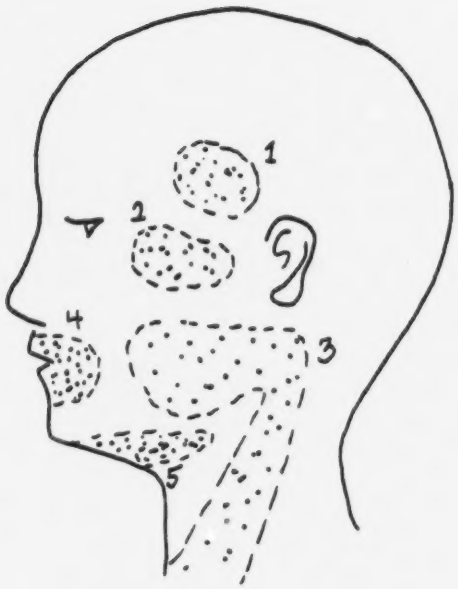
DYCEM - A non-slip material used under plates and other items to help keep them from sliding around.

Special cups, glasses and holders - Spout cups, cut out nose cups, pedestal cup, assorted cup holders and straws.

Remember to keep the whole process as simple as possible. Ask yourself these questions and consider the statements:

1) Is it really functional for the client?
2) Think of using the least equipment possible.
   a) People don't like being too different from those around them.
   b) Someone is going to have to keep up with any special equipment and be sure of its use and availability to the client on a consistent basis.

TECHNIQUES FOR DROOLING*



1. Activities that have already been mentioned for chewing, sucking and swallowing are invaluable in the development of the oral musculature and thus help to prevent drooling.

2. Brushing or vibrating (Use a fiber brush or battery operated vibrator for 3-5 seconds.)
   a. Brush or vibrate areas on illustration. When you brush or vibrate under chin from ear to ear, AVOID trip of chin.
   b. Wait a few minutes. Then use a slight rubbing pressure on each area (1, 2, 3, 4, 5).

3. Icing (for 3-5 seconds)
   Rub the ice around the lips. Then have the child suck on the ice for a few minutes. When trying to get your child to swallow, touch the ice to the hollow spot in the center of the base of the neck.

   After these procedures, you should resist lip closure with finger tips to help strengthen closing of the lips.

* A therapist will assist you with these techniques.

140

SELF-FEEDING

A child develops the ability to feed himself slowly and in conjunction with his improving ability to use his arms and hands. The child's first experience in self-feeding may be in helping to hold his own bottle. The child might progress to feeding himself a cookie, cracker or piece of toast with his fingers. Next he may try to help guide the spoon into his mouth. Following this, your child might begin drinking from a covered cup with a spout and begin experimenting with a spoon. Much practice is needed by the child to perfect the process of using a spoon. If coordination or strength is lacking, the process becomes more difficult for the parent and the child.

Equipment that might assist the child in the process of self-feeding:

1. Tommee-Tippee cup or Tupperware covered cup to help prevent spilling as the child begins to experiment with independent drinking.
2. Child's bowl with a suction base to attach firmly to the table.
3. Spoon with a bent or curved handle to accommodate the child's immature grasp.
4. Spoon with a bent or curved handle to accommodate the child's immature grasp.
4. Spoon with a built-up handle to assist a child who cannot close his hand completely.
5. Cuff which will hold a spoon onto the child's hand if he is not able to hold onto the spoon independently.
6. Spoon with the handle inserted through a hole in a rubber ball may make it easier for the child to grasp the spoon.

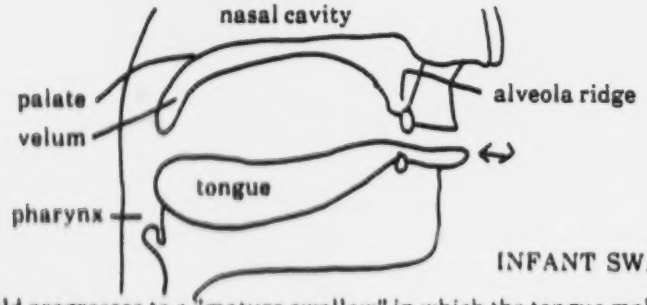
FEEDING

Correct feeding habits are important for good nutrition. For a handicapped child correct feeding habits are important for other reasons as well as nutrition.

If your child has weak muscles in his legs or arms, it is possible that his oral muscles around the mouth are also weak. These weak muscles may possible cause speech difficulties and problems in feeding.

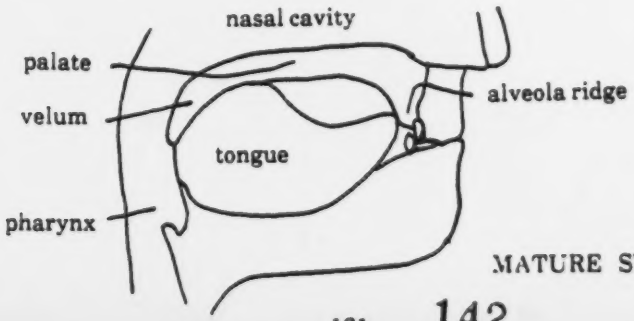
How can you best exercise your child's mouth muscles? The best mouth exercises are accomplished through the natural biological function of eating and drinking. Following are some ideas for developing the mouth muscles necessary for feeding and speech.

The young infant uses a sucking reflex to take milk from a bottle. This "infant swallow" is accomplished by an in and out movement of the tongue.



INFANT SWALLOW

Gradually the child progresses to a "mature swallow" in which the tongue makes contact with the ridge on the top front of the mouth (the alveolar ridge). When you swallow you are performing a mature swallow. Try this and see where the tip of the tongue goes. Now swallow one more time and notice the movement in the back of your mouth.



MATURE SWALLOW

All of the parts of the mouth (tongue, lips, palate and teeth) that are used in the process of feeding are also the parts that are used to produce speech sounds.

To help you understand how speech sounds are related to sucking and swallowing, try these sounds:

1. Try a "t" sound and a "d" sound. The tongue motions used with these sounds are similar to those used in the beginning phase of the mature swallow.

2. Now try a "k" sound and a "hard g" sound. The mouth movements in these sounds are similar to those used in the final phase of the mature swallow.

Activities to improve lip closure, sucking and swallowing and to decrease drooling:

1. If your child is very young and is still using a bottle, a Nuk-Sauger nipple and a Nuk pacifier will help to stimulate proper oral development. However the bottle should usually be discontinued by the time your child is 18 months of age.

2. When feeding your child, place the spoon fairly near his lips. Let him use his lips to reach out and take food from the spoon.

3. Cold and sweet substances help to stimulate sucking and swallowing. For this reason, popsicles are good for stimulation. Use ice or a popsicle in a circular motion around the lips for three to five seconds. Then allow your child to suck on the ice or popsicle for general stimulation.

4. Sucking through a straw is a good activity for strengthening the oral musculature. When practicing this activity it is necessary to use your child's favorite drink so that he will be rewarded for his efforts. Initially, it will be necessary for you to hold the draw in a horizontal position. Place your index finger over the end of the straw to hold liquid in it. When your child closes hip lips around the straw (or attempts this motion), quickly release your finger and allow the liquid to run into his mouth. After your child learns to close his mouth tightly around the straw, encourage him to suck on the straw. It may be necessary for you to set an example by exaggerating a sucking motion. Any slight sucking motion by your child should be rewarded with some of the liquid. As the child's sucking improves, you can gradually lower the straw until it is in a regular position in a glass.

5. Chewing gum is also a good activity to strengthen the mouth muscles. Tightly roll up a half stick of gum. Initially leave the gum in your child's mouth for only about 40 seconds, and then remove it. This is so he will get the idea that it is not supposed to be swallowed.

   Gradually increase the amount of time that you leave the gum in your child's mouth.

Activities to stimulate tongue movements

1. Place chocolate spread or peanut butter on the tip of your child's tongue. This will allow him to enjoy the pleasant taste of the substance and will motivate him to actively use his tongue and lips. Place chocolate spread or peanut butter around the outside of his mouth and encourage him to use his tongue to remove the substance. When he has removed the substance it will be necessary for him to use both his tongue and lips to move the substance around the inside of his mouth.

2. When you feed your child, place the food first on one side of the mouth then on the other, continuing to alternate sides.

Activities to stimulate chewing

1. Using a tongue depressor, back of a spoon, or even your fingers, "walk" back from the tip of the tongue to the back of the mouth. Stop before the child gags. Maintain pressure on the tongue until the tongue retracts and the child begins to swallows.

2. Begin infant foods as soon as it is recommended by your physician. If your child is already eating infant foods, it is important to proceed to junior foods. Then gradually advance to table foods cut into very small pieces. This progression of textured foods is very important to the muscular development of the mouth.

Activities to desensitize an overactive gag reflex

1. Using a tongue depressor, back of a spoon, or even your fingers, "walk" back from the tip of the tongue to the back of the mouth. Stop before the child gags. Maintain pressure on the tongue until the tongue retracts and the child begins to swallow.

2. Begin infant foods as soon as it is recommended by your physician. If your child is already eating infant foods, it is important to proceed to junior foods. Then gradually advance to table foods cut into very small pieces. This progression of textured foods is very important to the muscular development of the mouth.

GLOSSARY

ABDUCTION: movement of the limbs away from the midline of the body.
ACTIVE MOVEMENTS: movements a child does without help.
ADDUCTION: movements of the limbs towards the midline of the body.
ADNOSIA: loss of ability to recognize experiences from the special senses (i.e. visual and auditory) and from other parts of the body, i.e. touch.
AMBULATION: the act of walking about or moving.
AMELIA: absence of a limb or limbs.
ANTERIOR: in front of, or toward the head end of; "face" side of body.
APHASIA: inability to perform purposeful movements although there is not muscular or sensory loss or disturbance; loss or impairment of the ability to use words as symbols or ideas due to lesions in the cortex and association paths in the brain.
ASSOCIATED REACTIONS: increase of stiffness in spastic arms and legs resulting from effort.
ASYMMETRICAL: on side of the body different from the other - unequal.
ATAXIC: a type of cerebral palsy in which the child has no balance, he is jerky and unsteady, him movements are poorly-timed, grades and directed.
ATHETOID: a type of cerebral palsy in which the child has uncontrolled and continuously unwanted movements.
ATROPHY: wasting of muscles or nerve cells.
AUTOMATIC MOVEMENTS: necessary movements done without thought or effort.
BALANCE: maintaining equilibrium.
BILATERALLY: pertaining to or affecting both sides of the body.
BODY AWARENESS: knowledge of one's body - in terms of both the idea of its different parts and their relations to one another.
BRAIN STEM: the structure at the base of the brain connecting the upper end of the spinal cord with the cerebral hemispheres.
CARTILAGE: the "gristle" attached to bones to provide a slippery articulating surface.
CATHETER: a hollow tube for withdrawing fluids from body cavities, especially one for inserting into the bladder through the urethra.
CEREBRAL PALSY: disorder of posture and movement resulting from brain damage.
CHOREA: a nervous disorder characterized by irregular or involuntary jerky movements of the muscles of the extremities and the face.
CLONUS: shaking movements of spastic muscles after the muscles have been suddenly stretched.
CONGENITAL: existing from birth.
CONTRACTURE: permanently tight muscles and joints.
CONTRALATERAL: refers to the opposite side, usually concerns extremities (i.e. right arm. left leg).
CO-ORDINATION: the patterning of the action of the muscles of the body, i.e. their "working together" is controlled by the brain and is necessary for the maintenance of posture, for balance and the performance of movements.
CYANOSIS blue discoloration due to circulation of imperfectly oxygenated blood.
CYSTIC FIBROSIS: a hereditary disease of children involving defective production of enzymes in the pancreas, with disturbances throughout the body and usually with pulmonary involvement.
DEFORMITIES: body or limbs fixed in abnormal positions.
DEGENERATIVE: characterizing a change in tissue from a higher to a lower or less functionally active form.
DIABETES MELLITUS: a metabolic disorder of the pancreas, especially of the islets of Langerhans, resulting in faulty production of insulin, leaning to high blood sugar levels, loss of weight, and coma.
DIPLEGIA: a type of cerebral palsy with the legs being mostly affected, but often with some involvement of the arms.
DISTAL: farthest from the center, from a medial line or from the trunk.
DORSI-FLEXION: the lifting of the foot up towards the body.

DUCHENNE MUSCULAR DYSTROPHY: a type of muscular dystrophy causing progressive weakness of the limbs and trunk.
DYSLEXIA: impaired ability to read.
DYSTROPHY: defective or faulty musculature.
EPILEPSY: a central nervous system disorder marked by transient periods of unconsciousness or psychic disturbance, twitching, delirium, or convulsive movements.
ETIOLOGY: the total knowledge concerning the because of a disease.
EQUILIBRIUM: state of balance.
EVERSION: turning out of the foot.
EXTENSION: straightening of any part of the body.
FACILITATION: making it possible to move.
FLEXION: bending of any part of the body.
FLACCID: floppy (see hypotonia).
FLOPPY: loose of poor posture and movements.
GRAND MAL: a complete epileptic seizure, including sudden loss of consciousness, convulsion, spasm, incontinence, and frothing at the mouth.
HYPOTONIA (floppiness): decreased muscle tension, preventing maintenance of posture against gravity, also difficulty in starting a movement due to lack of fixation.
HANDLING: holding a moving with or without the help of the child.
HEAD CONTROL: ability to control the posture of the head.
HEMIPLEGIA: a type of cerebral palsy in which only one half of the body is involved. It is usually this type of child who shows asymmetry most clearly.
HYDROCEPHALUS: an abnormal condition in which there are excessive amount so cerebrospinal fluid in or around the brain, accompanied by enlargement of the head, prominence of the forehead, atrophy of the brain, and convulsions.
INHIBITION: a technical term used in treatment. Special techniques of handling are aimed at stopping the spastic or athetoid patterns which prevent or interfere with normal activity.
INVERSION: turning in of the foot.
KEY POINTS: parts of the body mostly proximal from which one can reduce spasticity and simultaneously facilitate more normal postural and movement reactions.
LATERAL: pertaining to the side.
MEDIAL: pertaining to the middle.
MOVEMENT: change of posture.
MONOPLEGIA: a type of cerebral palsy in which only one limb is affected - rarely seen.
MUSCLE TONE: the state of tension in muscles at rest and when we move- regulated under normal circumstances sub-consciously in such a way that the tension is sufficiently high to withstand the pull of gravity, i.e. to keep us upright, but it is never too strong to interfere with our movements.
MUSCULAR DYSTROPHY: hereditary disease, marked by progressive shrinking and wasting of skeletal muscle with no apparent lesion of the spinal cord.
NYSTAGMUS: continual involuntary rhythmic jerking of the eyes when turned sharply to the right or left.
OCCUPATIONAL THERAPY: treatment given to help the child towards the greatest possible independence in daily living.
ORTHOPEDIC SURGERY: surgery concerned with the straightening, preservation, and restoration of the musculoskeletal system.
PARAPLEGIA: paralysis of the legs and lower part of the body, caused by spinal injury, ataxia, brain lesions, and other factors.
PASSIVE: that which is done to the child without his help or cooperation.
PATHOLOGICAL: abnormal.
PATTERNS OF MOVEMENT: in every movement or change of posture produced by it, the brain throws muscles into action always in well coordinated groups that is in patterns.
PETIT MAL: a mild convulsive disorder related to epilepsy characterized by sudden brief blackouts of consciousness followed by immediate recovery.
PHYSICAL THERAPY: the treatment of disorders of movement.

POSTURE: position from which the child starts a movement.
PRIMITIVE MOVEMENTS: movements typical of a baby.
PLANTAR FLEXION: the pointing of the foot downward.
PRONATION: turning of the arm with palm of hand down.
PRONE: lying on tummy.
QUADRUPLEGIA: a type of cerebral palsy in which the whole body is affected.
REFLEXES: postures and movements completely beyond child's control.
RIGHTING: ability to put head and body right when positions are abnormal or uncomfortable.
RIGIDITY: very stiff posture and movements.
ROTATION: movement that takes place between hip and shoulder or vice versa
SCOLIOSIS: a lateral or side-to-side curvature of the spine in the shape of an elongated letter S.
SKILL: ability to perform a task.
SPASM: sudden tightening of muscles.
SPASTICITY: stiffness.
SPINA BIFIDA: a congenital cleft in the bony encasement of the spinal cord, with meningeal protrusion.
SPINAL CORD: that part of the central nervous system contained within the vertebral column.
STRABISMUS: failure of the eyes to converge properly on an image, leading to squint, cross eye, or walleye.
SUPINATION: turning of the arm with palm of hand up.
SUPINE: lying on back.
SYMMETRICAL: both sides equal.
TONIC NECK REFLEX: when the turning of the head causes one arm to straighten and stiffen and the other to bend and stiffen.
TREMOR: involuntary trembling or quivering in one or more parts of the body, usually in the extremities. An intention tremor is not evident when the part is at rest, but begins as soon as the part is put into action.
TRUNK: the body as distinct from the limbs.
VALGUS FEET: flat feet.
VOLUNTARY MOVEMENTS: movements done with intention and with concentration.

Compiled fro:
A MEDICAL ATLAS FOR TEACHERS
HANDLING THE YOUNG CEREBRAL
PALSIED CHILD AT HOME

FEEDING THE MULTIHANDICAPPED CHILD

Summary

1. Seat the child so that his body is aligned symmetrically.
2. Be sure the child is facing straight ahead and that his head is not tipped back.
3. Sit in front of the child and on the same level or slightly below him.
4. Bring the food toward the child slowly and from the front, in the middle and at the level of his mouth--never from above him.
5. Spoon feeding
   a. Bring the spoons straight into the mouth without touching the teeth or gums.
   b. Press downward slightly on the tongue with the spoon.
   c. Pull the spoon out slowly, pulling upward slightly, waiting for the lips to close around the spoon and pull the food off.
6. Biting and Chewing
   Bring the food straight into the mouth and place it between the teeth or gums slightly to either side of center.
7. Cup Drinking
   a. Place the cup between the lips--not between the teeth or gums.
   b. Bring the liquid up just to the edge of the cup so that the child can pull it into his mouth with his upper lip. Don't pour in the liquid.
   c. Stop the flow of liquid and remove the cup from the child's lips so that he can stop and breathe.
8. Give the child plenty of time at each step.

Biting and Chewing

Goals: 1. The child's mouth should open as food approaches.

2. When food is placed between the teeth or gums, the child should bite down hard enough and long enough to bite through the food.

3. The child should begin chewing spontaneously.

4. The child should not lose food out of him mouth while he eats.

What to do to Achieve This:

1. Bring the food toward the child slowly from the front so that he has time to see what is happening and respond. If he doesn't open his mouth spontaneously, tell him to "Open" and wait. If he doesn't open his mouth after a reasonable length of time, place your index finger horizontally across his chin and pull down gently. Continue telling him to "Open" while you do this so that he can begin to connect the action with the word and may eventually open his mouth without assistance.

2. Bring the food straight into the mouth and place it between the teeth or gums slightly to either side of center.

3. If the child doesn't bite down spontaneously,stimulate the molars by pressing into them with either the food or with a wash cloth over you finger. Be careful with your finger if you think the child might have a bite reflex.

4. If the child loses food from his mouth while eating, bring up the lower lip with your thumb and index finger.

5. Give the child plenty of time at each step.

Spoon Feeding

Goals:

1. The child's mouth should open as food approaches.
2. The child's tongue should flatten and cup slightly as he receives the food into his mouth.
3. The child's lips should close around the spoon and actively pull the food off.
4. The child should begin chewing spontaneously.
5. The child should not lose food out of his mouth while he eats.

What to do to Achieve This:

1. Bring the food toward the child slowly from the front so that he has time to see what is happening and respond. If he doesn't open his mouth spontaneously, tell him to "Open" and wait. If he doesn't open his mouth after a reasonable length of time, place your index finger horizontally across his chin and pull down gently. Continue telling him to "Open" while you do this so that he can begin to connect the action with the word may eventually open his mouth without assistance.
2. Bring the food straight into the mouth without touching the teeth or gums to discourage a bit reflex.
3. Press downward slightly on the tongue with the spoon to encourage the tongue to flatten and cup.
4. Pull the spoon out slowly, pulling upward slightly as you do so, waiting for the lips to close around the spoon and pull the food off.
5. If the child does not chew spontaneously, you may try placing food on his molars or stimulating them by rubbing them with a wash cloth over your finger. Be careful with your finger if the child as a bit reflex.
6. If the child's lips do not close around the spoon or if he is losing food from his mouth while eating, you can bring up the lower lip with your thumb and index finger.
7. Give the child plenty of time at each of the steps.

Materials that Can Help:

1. Mothercare spoons--
   plastic is less temperature sensitive--helps avoid a bit reflex when heat or cold touches the child's teeth or gums

   shallow bowl--encourages the lips to close around the spoon and discourages tongue thrust
   two sizes--spoon is large enough to fill child's mouth comfortably without touching teeth or gums
2. Ground and Pureed Foods--allows the child to begin to experience variety and texture in his food while still having foods that he has the skills to eat.

Positioning

Goals: 1. The child's body should be aligned symmetrically with the head and neck in midline.

2. The child's head should face straight ahead. It should not be turned to either side nor allowed to tip back while eating.

3. Children who have enough control to sit upright should sit up on their bottoms with their hips touching the back of the chair. Their feet should be flat on the floor and elbows just at tabletop level.

4. Children who do not have enough control to sit upright will need to be supported in a slightly reclined position in either a special chair or in the feeder's arms.

What to do to Achieve This:

1. Before beginning to feed the child, look to see if he is well positioned.

2. Monitor the child's position during feeding. Obviously, the child will move around and should be allowed to do so, however,aim to return the child to alignment as often as possible.

3. To encourage the child to look straight ahead while eating, sit in front of him and on the same level or slightly below him.

4. Bring the food toward the child from the front, in the middle and at the level of his mouth.

Materials that Can Help:

1. Foot Block--any sturdy (probably wooden) block which can be placed under the child's feet so that they are flat and do not dangle

2. Adaptive Chairs--give more support to children who can sit upright but who will not sit up well in a regular chair

3. Seat Belts--help keep the child's hips against the back of the chair

4. Sandals with Straps--help keep the child's feet flat and help keep him from sliding out of position if he can't control his legs

5. Trays--usually fit onto a wheelchair or adapted ;chair--gives the child a surface to push against to help him stay upright

6. Feeder Seat--for the child with insufficient body control to sit upright--helps keep the body in alignment and the head from tipping back

Why Positioning:

For many of our children,both sitting and eating require so much concentration and effort that it is not possible to do both well simultaneously. The better the child is positioned, the more free he and the feeder will be to concentrate on his eating. Proper positioning also allows the child to use the best skills he has in eating and helps to prevent choking or aspiration.

PHYSICAL CARE OF DEAF-BLIND AND MULTIHANDICAPPED CHILDREN

I. Hygiene and Communicable Diseases

A. How communicable diseases are transmitted.

Table I

TRANSMISSION CONCERNS IN THE SCHOOL SETTING
BODY FLUID SOURCE OF INFECTIOUS AGENTS

BODY FLUID-SOURCE	ORGANISM OF CONCERN	TRANSMISSION CONCERN
Blood -cuts/abrasions -nosebleeds -menses -contaminated needle	Hepatitis B. virus AIDS virus Cytomegalovirus	Blood stream inoculation] through cuts and abrasions on hands Direct blood stream inoculation
*Feces -incontinence	Salmonella bacteria Shigella bacteria Rotavirus Hepatitus A Virus	Oral inoculation from contaminated hands
*Urine -incontinence	Cytomegalovirus	Bloodstream and oral (?) inoculation from contaminated hands
Respiratory Secretions -saliva 0nasal discharge	Mononucleosis Common cold virus Influenza virus	Oral inoculation from contaminated hands
	AIDS virus ..... Hepatitus B virus	Bloodstream inoculation through cuts and abrasions on hands; bites
*Vomitus	Gastrointestinal viruses, e.g., (Norwalk agent Rotavirus)	Oral inoculation from contaminated hands
Semen	Hepatitus B AIDS virus Gonorrhea	Sexual contact (intercourse)

* Possible transmission of AIDS and Hepatitis B is of little concern from these sources. There is no evidence at this time to suggest that the AIDS virus is present in these fluids.

I. HYGIENE AND COMMUNICABLE DISEASE

A. How Communicable Diseases are Transmitted - continued

Preventing the Spread of Infection

1. **Maintain good health - Personal Health Habits**
   a. Personal Cleanliness and Positive health practices (protect health of yourself and others by practicing good health habits, i.e., coughing, sneezing prevent exposing other - stay home when ill, etc.)
   b. Proper exercise
   c. Proper Nutrition
   d. Adequate rest and sleep
   e. Positive mental health - reduce stress factors as much as possible

2. **Proper Handwashing** - (see attached sheet)

3. **Good Personal Hygiene** within school environment
   a. no smoking near food
   b. Clean to clean - Dirty to dirty (i.e., Do not eat in the same area where diapers are changed.)
   c. Do not share utensils or drinking cups
   d. Hug rather than kiss students
   e. Remove jewelry before "dirty" jobs

4. **Practice good environmental health when**:
   a. Cleaning of body fluids
   b. Cleaning of soiled area
   c. Disposing of trash
   d. Using of gloves if skin is broken or cut

B. Methods of Disinfecting Materials, Equipment and Clothing

1. **Clothing**
   a. Remove as much soil as you can
   b. Washable clothing, wash in washing machine, use regular laundry detergent in recommended amounts.
   c. Sun drying or automatic driers will additionally sanitize clothing.
   d. If you have cuts on your hands you can use disposable gloves to protect open areas, otherwise wash hands with soap and water at a sink.

2. **Equipment - Materials**

   a. Rinse with tepid water to remove disease producing material.
   b. Wash with hot, soapy water
   c. Rinse to remove soap (Hot Water)
   d. Dry
   e. Disinfect if indicated

Wash all washable toys at the end of the school day.

II. Administration of Medication

A. Consultation with Supervising Teacher.

Oklahoma Law

Personnel authorized to administer medicine at school:

1. School Nurse
2. School Principal
3. School employees designated by the principal

Medication administered only with written authorization of parent.

1. Know individual school district policy - procedure for giving medication
2. Require permission for giving medication signed by parent/guardian before giving medication.

B. Considerations and Procedures for Administering Medication

1. **District Procedure**
   Clearly defined school policies should provide guidelines to follow in the administration of medication.

2. **Permission/Release Forms signed by parent**
   Follow district policy - secure forms and signatu[illegible]efore medication is given.

3. **Proper Storage**
   Designated place for storage should be in a secure area (able to be locked) preferably office area. Cool area. Read labels for directions of specific storage area.

4. **Recording Administrations**
   a. Maintain records of all medication given
   b. Record - date, time, name of medication and amount given and signature of person who gave the medication.

5. **Directions for Administering**

   a. Learn about medication to be given so that side effects can more easily be recognized.

   b. Check label of medication - it should contain:
      Name of student
      Name of medication
      Dosage of medication to be given
      Instructions and time medication should be given
      Date of prescription

   c. Wash Hands

Directions for Administrations - continued

d. Prepare medication for administration -
Place tablets or capsules into cap and pour the correct number of tablets or capsules into the medicine cups or receptacle for dispensing.
e. Return Medication to proper storage
f. Check to be sure you have proper student
g. Explain to student
h. Give medication
i. Stay with student until all the medication is swallowed.
j. Wash hands
k. Place supplies appropriately
l. Record

Safety Assurance -
right drug - in the **right amount**, is given to the **right person** at the **right time** in **the right manner.**

III. **Orientation to First Aid Procedures**

Goal of emergency care is to give initial treatment in order to prevent death of permanent injury caused by an accident of sudden illness.

Attitude - it is important for people to be in control. In any crisis someone needs to take control.

Legal - Good Samaritan Law in Oklahoma
Person is covered so long as you perform at your peer level, in good faith, doing what you have been taught to do.

Key in emergency situations is first Response
Primary assessment
Secondary assessment

Primary Assessment
1. Look around, figure out what happened
2. Protect yourself
3. Take care of problem

Secondary assessment - 90 second assessment
from Head to Toe
Skin
Head
Eyes
Facial Bones
Ears
Neck
Mouth
Chest
Abdomen
Backside
Pelvis
Extremities
PMS

III. Orientation to First Aid Procedures - continued

A B C's First Aid
Airway
Breathing
Control Circulation
Control Bleeding

[A] Airway - Most common problem unconscious person - tongue falls to back of throat blocks airway - open airway.
One hand under neck - other hand on top of forehead pulls jaw up.

[B] Breathing
look
listen
feel
Normal breathing rate 12 per minute adult
20 per minute child

Abnormal
1. Rapid, shallow - shock
2. Deep, gasping, difficult - airway obstruction
3. Decreases chest movement - not taking enough air in.
4. Frothy, bubble and bloody fluid in lungs
5. Unusual odor - Alcohol, Acidosis diabetes (finger nail polish remover)

[C] Circulation
Check pulse - 60 - 100 per minute, adult
80 - 120 per minute, child
radial - easiest to take
corroded - easiest to find - last to go
Blood Pressure - Systatic - blood forced out against arteries
Diastalic - at rest

Pulse Abnormalities
1. Rapid, weak - Blood loss
2. Rapid, full - freight - High Blood Pressure
3. Absence - obstruction of artery or heart not beating

Control Bleeding - 3 pint loss - fatal (10 to 12 pints in minute)
2 pint loss serious
can bleed to death - 3 minutes
Direct Pressure - best way to control - put hand over and push
Pressure points - any where you find a pulse is a pressure point
Venous - coming back to heart
Artery - leaving heart

III. Orientation to First Aid Procedures - continued

A. What to do in Emergency Situations

1. **Choking**
The most common cause of airway obstruction in an unconscious person is obstruction of airway by the tongue. The universal distress signal characterizing an apparent obstructed airway in the conscious adult is the victims hand at this throat.

2. **Bleeding**
General

a. Moderate bleeding can be controlled by exerting pressure on a sterile gauze or clean dry cloth over the bleeding site with the fingers on hand.

b. If direct pressure does not stop the bleeding then the pressure points or a tourniquet should be used until medical care is obtained. However, the tourniquet should not be used unless the first two methods fail.

c. Notify the parent and in case of profuse bleeding, get the child to a physician or hospital as soon as possible.

3. **Severe bleeding from wound**

a. Apply gauze and pressure directly over the wound to control bleeding.

b. Elevate bleeding part if feasible

c. Add more dressing if necessary.
DO NOT remove previous dressing, bind in place.

d. If fingers or other parts are severed, save the part in a clean, plastic bag, enclosed in ice or wrap the part in water soaked gauze and place over ice.

e. Treat for shock, if indicated.

f. Secure prompt medical care.

4. **Bleeding Internal**

a. Keep student warm and lying down.

b. If there are breathing difficulties or if blood is coming from the mouth, elevate head and shoulders.

c. Make sure there is an adequate airway.

d. Secure prompt medical care.

III. Orientation to First Aid Procedures - continued

5. **Nosebleed**

   a. Keep the child in sitting position and apply cold compress to forehead, over nose, and on back of neck.

   b. Squeeze the nostrils shut between the thumb and index finger for four or five minutes to allow a clot to form.

   c. Child should not blow nose of several hours.

   d. If bleeding persists, contact parents and advise them to seek medical care.

6. **Injuries to Head and Neck**

   Caution:
   A head injury resulting in unconsciousness requires medical attention.

   Danger Signals - Nausea - Vomiting
   Dizziness
   Severe Pain
   Unusual Drowsiness
   Uncoordinated motor skills
   Confused or disoriented behavior
   Unequal dilation of pupils

7. **Head Injuries**

   a. Keep student lying down and quiet.

   b. If unconscious follow instructions for fainting.

   c. Control bleeding by applying dressings directly on the wound. If blood soaked, do not remove original dressing, add more.

   d. Observe carefully and constantly. Seek prompt medical attention if there is nausea, vomiting, irregular pulse irregular pupils, drowsiness, twitching, unconsciousness, bleeding from ears or mouth.

   e. Even if student was only briefly unconscious and seems fully recovered, contact parent and urge that student use a doctor. DO NOT allow student to resume play in any active game or sport on that same day.

   f. Student should be under observation 24 hours at home for any of the above symptoms. Notify parent.

   g. Nothing by mouth if nausea - vomiting.

III. Orientation to First Aid Procedures - continued

8. **Neck Injuries** (Back or Spine)

a. Movement of person

1) Do not move person unless absolutely necessary, such as in a dangerous environment (e.g., falling debris). Keep person in original position of injury.

2) If necessary to move, keep head, neck and shoulders in the same alignment position. Move the body as a whole. This requires at least three persons.

b. Maintain breathing

c. Control bleeding (See Bleeding)

d. Keep warm and comfortable

e. Treat for shock if necessary

9. **Seizures**

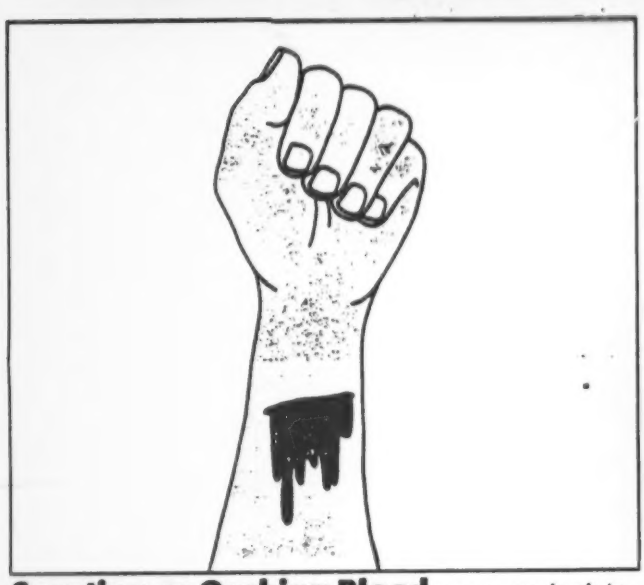
Definition - an involuntary contraction or a series of contractions of muscles resulting from abnormal cerebral stimulation.

Students with seizure disorders should be identified as having a special medical condition. You cannot stop a seizure once it has started.

Main Goal of Care - Prevent injury to student

a. Insure adequate airway
b. Clear the area around student
c. Do not interfere with movements unless to prevent injury.
d. No force to prey mouth open if airway clear
e. Protect head if possible. Protect from injury. Remove nearby objects. Prevent student from striking head or body on hard,sharp or hot objects.
f. Loosen constructed clothing
g. When conscious turn on side to facilitate drainage of mucous - saliva
h. Provide privacy and protect dignity of the individual student who has seizures.
i. Start with student until conscious
j. Keep airway open. If breathing stops, give artificial respiration.
k. After seizure - allow to rest. Do not let student go home alone.
l. If prolonged or repeated seizure, secure prompt medical attention.
m. Always notify parents.
n. Observe details of seizure and report to parent.
o. Urge medical care following a first seizure.
p. Reassure students in same area.

HOW TO STOP SEVERE BLEEDING.



Spurting or Gushing Blood can cause death in minutes. You can save the life of a bleeding person by acting quickly.

Cover the Wound with a thick, clean compress. If you do not have a handkerchief or piece of clothing, use your hand.

Press Hard and Elevate the wound above the heart. Don't elevate if movement causes pain.

Send for Emergency Help. Send someone else so you can stay with the victim.

American Red Cross

III. Orientation to First Aid Procedures - continued

10. **Fainting**

Temporary loss of consciousness due to cerebral anemia or insufficient blood to brain.

Symptoms

Pallor
Shallow breathing
Slow, weak pulse
Short periods of unconsciousness

Treatment

a. Lower patients head between knees or have lie down.
b. Keep person lying down until fully recovered
c. Maintain a open airway, keep head turned to side
d. Loosen clothing around neck and waist.
e. DO NOT pour anything on the students face.
f. DO NOT give anything to drink unless fully conscious.
g. If student fails to respond seek prompt medical attention.
h. If breathing stops, begin artificial respiration.
i. Notify parent in all cases

11. **Asthmatic Reactions, Burns**

a. **Asthma**

Caution:
Asthmatic children should be identified as having a special medical condition.

Definition
Condition of the lung in which there is airway obstruction due to spasm of the bronchial smooth muscles, edema of the mucous, and increased mucous secretions in the bronchi and bronchials that has been brought on by various stimuli.

Treatment

1. Position upright to allow maximum lung exposure
2. Reassure, make comfortable sitting or reclining - talk calmly, gently.
3. May give sips tepid water
4. Keep student cool
5. Administer medication if one has been prescribed by the students doctor.
6. Remove known allergies, i.e., smoke, plants.
7. Notify parent.

III. Orientation to First Aid Procedures - continued

b. **Burns**

Chemical burns on the skin

1) flush area a thoroughly for at least five (5)minutes with cool water.
2) Apply clean dry dressing
3) Notify parent - seek medical attention if necessary.

Limited burns (skin reddened, small area blistered)

1) Immerse burned area in cool water for at least five (5) minutes.
2) Apply dry sterile dressing.
3) Notify parent.

Extensive or severe burns (large area blistered,charred etc.)

1) If possible, cut away clothing from burned area. If clothing sticks leave alone.

2) Immerse burned area in cool water to decrease pain and tissue damage. DO NOT immerse an extensively burned area. Cold may intensify shock reaction.

3) Cover with dry gauze or clean cloth.

4) Keep victim lying down.

5) Treat for shock if indicated.

6) DO NOT use antiseptic preparation ointment, spray, or home remedy on a severe burn.

7) Secure prompt medical attention.

12. **Shock**

Symptoms of shock usually are paleness, cold sweat on forehead, cold and clammy hands. There may be nausea, dizziness, weakness, ashen gray appearance, rapid and weak pulse,shallow or irregular breathing.

a. Position child on side so that the saliva can drain and keep airway open.

b. Keep the child warm, with feet slightly elevated.

c. Do not overheat the child.

d. Notify parent and secure medical care immediately.

HANDWASHING TECHNIQUE

OBJECTIVE: To prevent spread of infectious germs by proper handwashing.

INTRODUCTION

Proper handwashing is done in order to prevent the spread of infectious germs by the hands to another person.

Methods of transmitting germs by hand.
1. Directly - hand to mouth
2. Indirectly - objects: glass, cup, bottle

Handwashing involves the following action:

1. Chemical -
   Soap - may contain germicide because of the presence of infectious germs. Soap emulsifys and lowers surface tension and this facilitates removal of germs.
2. Mechanical - running water, friction of rubbing.

Length of time required to cleanse hands adequately: Usually one to two minutes

Equipment:
1. Soap
2. Warm water - running
3. Paper towels

Added equipment for meticulous handwashing

a. Scrub brush
b. Finger nail file

Procedure
1. Fingernails - care - keep filed short.
2. Turn on water - water needs to be warm comfortable to touch. Excessively hot water opens pores and can irritate the skin.
3. Hold hands below the level of the forearms and wet thoroughly. The hands will be more contaminated than the forearms, hence the water should run from the area of least contamination(the forearms) to the area of greatest contamination (the hands).
4. Apply a few drops of surgical soap, from the soap dispenser, over the hands and forearms.
5. Wash each hand thoroughly, using a rotary motion. Wash each finger separately, and make sure the interdigital spaces are well cleaned. Continue for one or two minutes.
6. Cleanse nails and fingertips with a brush. Rinse brush before returning to a clean storage area around sink. The scrub brush needs to be soaked in Virex solution at the end of each day for 30 minutes then air dried. If the scrub brush becomes contaminated do not use it. Obtain a clean one. Soak the contaminated brush in Virex for 30minutes before using it again.
7. Rinse hands so that water flows from the arms to the hands.
8. Repeat steps 3 through 6.
9. Dry the arms and hands starting at the forearms and working towards the hands. Discard the towel after it has reached the hands.
10. Turn off the faucet, using a paper towel if it has a hand control, because the handle is contaminated.

If while washing the hands, they accidentally touch a contaminated object, such as the sink or the faucet, handle, the handwashing procedure needs to be repeated from the beginning. If the hands are dry and cracked from frequent washing, it is advisable to use a lubricating lotion or cream. The same handwashing procedure should be used between the handling of each child. This handwashing procedure should last about 20 seconds.

DAILY CLEANSING FOR CLASSROOMS AND EQUIPMENT

OBJECTIVE: To explain medical asepsis and establish a uniform method of cleaning contaminated school area on a daily basis.

Introduction:

Microorganisms are always present in the environment. Some live on the skin, others are common inhabitants of the intestinal track, and others are found, among other places, in the air, in the soil, and on our clothes. Most of these microorganisms to not produce disease. The control of the spread of pathogens and the protection of people from the acquisition of infectious diseases are our concerns. Protection from disease is very much an individual responsibility. An infection is the invasion of the body of a person by pathogenic organisms that multiply and overcome the flora normally present and the subsequent physiologic reaction of the body to these organisms.

Asepsis refers to the absence of all disease producing microorganisms. When hands are washed with a disinfectant, they can be considered to be aseptic. Medical asepsis is concerned with limiting the spread of microorganisms. It includes these practices which are intended to confine a specific microorganism to a specific area.

Once a pathogen has escaped its reservoir, then it must have a means of transmission to another person or host. There are various vehicles to carry the organisms to a person. Some of these are direct contract, air, food and water.

Once a pathogen has escaped its reservoir, then it must have a means of transmission to another person or host. There are various vehicles to carry the organisms to a person. Some of these are direct contact, air, food and water.

When a person is ill, there are specific measures that can be employed to restrict the spread of microorganisms. An article is considered clean when it is free of pathogenic organisms. An article that has pathogens on it is considered dirty or contaminated. Most articles can be cleansed by rinsing them in tepid water to remove any organic material, washing them with hot soapy water, then rinsing them again to remove the soap. the following steps should be considered when cleaning in a classroom or home setting where pathogens exist.

Equipment:

Tepid water, warm water, clean cloth or sponge, mop, bucket, spray bottle Virex

Procedure:

1. Rinse the article with tepid water in order to remove organic material. Hot water coagulates the protein of organic material and tends to make it stick to the article.

2. Wash the article in hot water with soap. Soap has an emulsifying action and reduces surface tension, which facilitates the removal of dirt. Rinsing with water assists in washing the dirt away.

3. Rinse the article well with hot water.

4. Dry

5. Disinfect if indicated.
   Disinfection is the process by which most microorganisms are destroyed, with the exception of spores. Various methods exist for disinfecting object. There are chemicals that work either by interfering with the metabolism of microorganisms or by destroying the protoplasm of the organism. There are basically two types of anti-infectives, and we will be using those which are applied for local action, such as disinfectants and antiseptics on the skin, or to body excretions such as urine or saliva.

Procedure:

1. Rinse the mats, crib, wheelchairs, toys, etc. with cold water in order to remove any organic material.

2. Spray all the contaminated articles with Virex and wipe, using brisk strokes creating friction.

3. Air dry the article being cleansed.

4. Cleanse all articles daily that are used by the children.

5. Toys may safely be soaked in the Virex solution, then rinsed in water before being air dried.

6. Floor and rugs that are contaminated need to be wet-mopped with the virex solution daily. Do not rinse the area.

SOURCES CONSULTED

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Kozier, Barbara, BSN, RN; Erb, Glenora Lea, BSN, RN, *Fundamentals of Nursing Concepts and Procedures*

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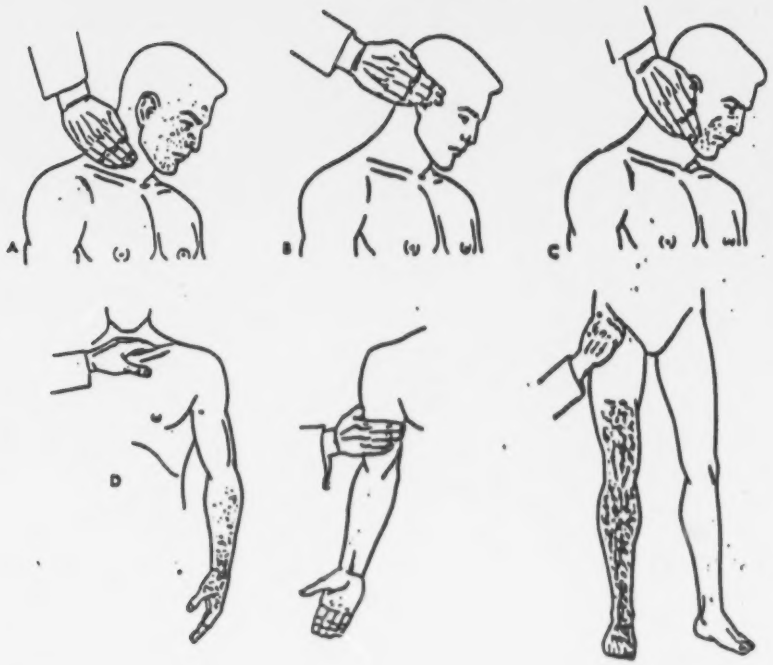
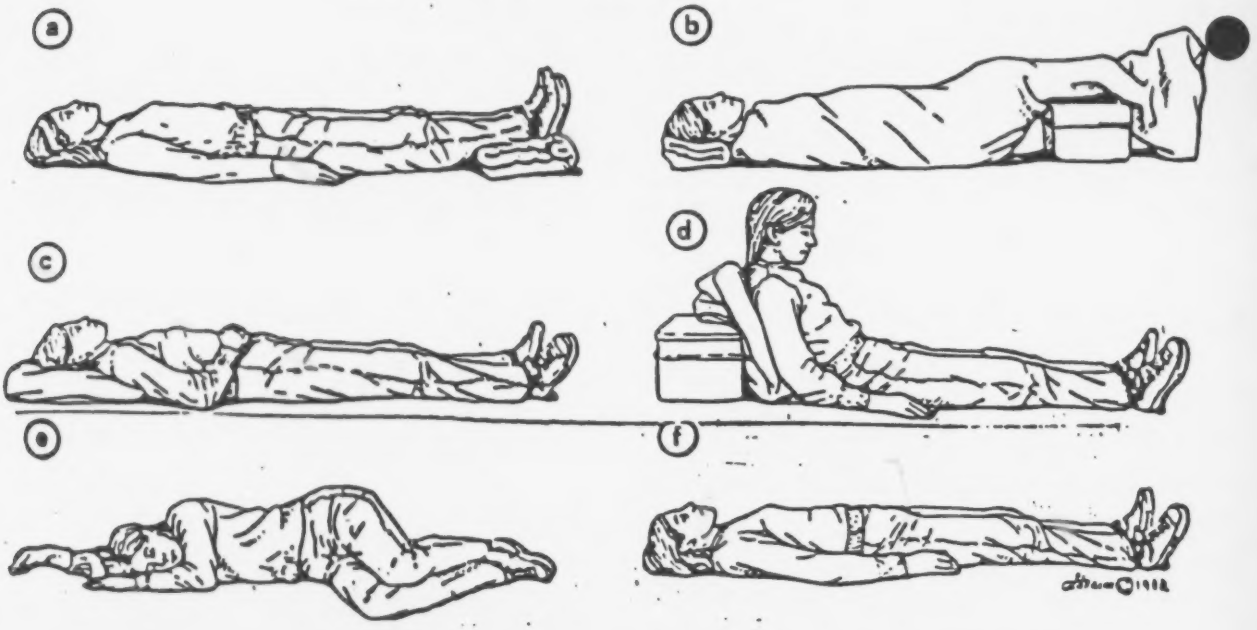
DIGITAL PRESSURE POINTS



More commonly used digital pressure points. Shades areas are those within which hemorrhage may be controlled by pressure on the specific artery. A, Carotid; B, temporal; C, external maxillary; D, subclavian; E, brachial; F, femoral. (From Crawford: Nursing Clinics of North America, June 1967.)

BODY POSITIONING FOR SHOCK



a. & b. Lower extremities should usually be elevated to improve blood supply to the heart. If the legs are fractured they should not be elevated unless they are well splinted.

c Elevate the head slightly, with possible head injuries, to reduce pressure on the brain. (Do not elevate head if there is mucus in there throat.

d. Raise head and shoulders to a semi-sitting position if breathing difficulty.

e. If person is unconscious, place them on their side in recover position.

f. Depending on the circumstances the person may need to be left in the position in which he was found.

OKLAHOMA CITY PUBLIC SCHOOLS

Department of Health

CLASSROOM SEIZURE RECORD

STUDENT'S NAME _____ DATE _____

TIME _____

HOW LONG DID THE SEIZURE LAST: _____

WHERE DID THE SEIZURE BEGIN? (HAND, FACE, FOOT) _____

ON WHICH SIDE OF THE BODY DID THE SEIZURE BEGIN? _____

DID THE HEAD OR EYES TURN TO THE RIGHT OR LEFT _____

DID THE SEIZURE PROGRESS TO ANOTHER AREA OF THE BODY? WHERE? _____

WHAT WAS THE CHILD'S BEHAVIOR AFTER THE SEIZURE? (SLEEPY, CONFUSED) _____

_____

What was the child's behavior before the seizure? (Precipitating events) _____

_____

Was there loss of consciousness _____

_____

Was there loss of posture? _____

Did the child stare, lick lips, pick at clothes? _____

Was there incontinence of urine? _____

Was there stiffness, jerking and tongue chewing? _____

Have you noted staring and nonresponsiveness in the child? _____

How long did it take the child to recuperate and return to normal activity? _____

_____

Did the child sleep after the seizure? _____

Were there repeated seizures during the day? _____ How many? _____

Medication and dosage given at school _____

_____

Additional information: _____

_____

American Red Cross

GENERAL DIRECTIONS FOR GIVING FIRST AID

Keep the injured person lying down. Do not give liquids

to an unconscious person. Restart breathing with mouth-to-mouth

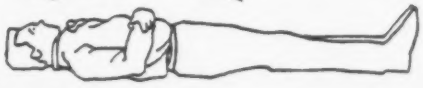
artificial respiration. Control bleeding by pressing on the wound.

Dilute swallowed poisons and call the Poison

Control Center. Keep broken bones from moving. Cover burns

with thick layers of cloth. Keep heart-attack cases quiet and give

cardiopulmonary resuscitation (CPR) if it is necessary and if you

have been trained. Keep a fainting victim lying flat. 

For eye injuries, pad and bandage both eyes. Always call a doctor.

For more information about these and other lifesaving techniques, contact your Red Cross chapter.

168

FIRST AID STANDING ORDERS

1. BLEEDING: Apply direct pressure, elevate, add dry, clean dressing only if blood soaks through.

2. CHOKING: Conscious
   If victim can cough, speak, and breath, DO NOTHING!
   If victim cannot cough, speak, or breath, give 4 back blows,
   4 abdominal thrusts, repeat.

   Unconscious
   Give 4 breath, 4 back blows, 4 abdominal thrust, finger sweep, repeat.

3. CPR: Do a QUICK CHECK!
   Give 15 compressions, 2 breaths for adults
   rate of 80/minute
   Give 5 compressions, 1 breath for child or infant
   rate 100/minute

4. FAINTING: Have student lying down with feet elevated.

5. FRACTURES: DO NOT MOVE affected area
   Seek medical attention

6. HEAD INJURIES: Have student lying down, check breathing,
   obtain medical attention.

7. NOSEBLEED: Have student sit upright and pinch nose.

8. PENETRATING OBJECTS: DO NOT REMOVE object from wound,
   immobilize object before moving student.

9. SEIZURES: DO NOT RESTRAIN victim, prevent injury, turn on side,
   check breathing, loosen tight clothing, allow to rest.

10. SHOCK: Have student lying down with feet elevated.

11. SUDDEN ILLNESS: (heart, stroke, diabetes, asthma, drugs)
    check breathing, obtain medical care immediately.

EMERGENCY TELEPHONE NUMBERS

Rescue Squad _____

Fire Department _____

Police _____

Physician _____

Hospital Emergency Room _____

Poison Control Center _____

Additional Numbers _____

_____

When you call for emergency help, tell:

1. WHERE the emergency situation is, with cross streets if possible.
2. TELEPHONE NUMBER you are calling from.
3. WHAT HAPPENED–heart attack, auto accident, fall, etc.
4. HOW MANY persons need help.
5. WHAT is being done for the victims.

NOTE: YOU HANG UP LAST. Let the person you called hang up first.

Record and post emergency telephone numbers in advance so that they will be readily available when you need them.

The programs of the American Red Cross are made possible by the voluntary services and financial support of the American people.

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170

First Aid For Choking

1

- **ASK: Are you choking?**
- If victim cannot breathe, cough, or speak...

2

- **Give the Heimlich Maneuver.**
- Stand behind the victim.
- Wrap your arms around the victim's waist.
- Make a fist with one hand. PLACE your FIST (thumbside) against the victim's stomach in the midline just ABOVE THE NAVEL AND WELL BELOW THE RIB MARGIN.
- Grasp your fist with your other hand.
- PRESS INTO STOMACH WITH A QUICK UPWARD THRUST.

3

- **Repeat thrust if necessary.**

- **If a victim has become unconscious:**

4

- Sweep the mouth.

5

- Attempt rescue breathing.

6

- Give 6-10 abdominal thrusts.
- Repeat Steps 4, 5, and 6 as necessary.

American Red Cross

FIRST AID FOR CHOKING
INFANT (TO APPROX. 1 YEAR)

WE'RE FIGHTING FOR YOUR LIFE
American Heart Association

CONSCIOUS VICTIM

1 When obstruction by a foreign object is strongly suspected:
If the infant can cry, cough, or breathe, do not interfere.

2
If the infant cannot cry, cough, or breathe, deliver 4 back blows —

3
followed by 4 chest thrusts.

Repeat back blows and chest thrusts until the foreign object is expelled or the infant becomes unconscious.

IF VICTIM BECOMES UNCONSCIOUS

1
Using tongue–jaw lift, open mouth.
If foreign object is seen, take it out.

2
Open airway (head-tilt/chin-lift);
perform mouth-to-mouth/nose rescue breathing.

3
then
If unsuccessful, deliver 4 back blows followed by 4 chest thrusts.

BE PERSISTENT

Activate Emergency Medical Services as soon as possible.

Repeat sequence of tongue–jaw lift, rescue breathing, blows, thrusts.

Continue uninterrupted until advance life support is available.

CALL-FOR-HELP NUMBER:

_____

FIRST AID FOR CHOKING
CHILD (APPROX. 1 TO 8 YEARS*)

American Heart Association

CONSCIOUS VICTIM

1

When obstruction by a foreign object is strongly suspected:

Ask the child, "Are you choking?"
If the child can speak, cough, or breathe, do not interfere.

2

If the child cannot speak, cough, or breathe, apply subdiaphragmatic abdominal thrusts (the Heimlich maneuver) until the foreign body is expelled or the child becomes unconscious.

IF THE VICTIM BECOMES UNCONSCIOUS

1

Using tongue–jaw lift, open mouth.
If foreign object is seen, take it out.

2

Open airway (head-tilt/chin-lift); perform mouth-to-mouth rescue breathing.

3

If unsuccessful, apply 6–10 subdiaphragmatic abdominal thrusts.

BE PERSISTENT

Activate Emergency Medical Services as soon as possible.

Repeat sequence of tongue–jaw lift, rescue breathing, abdominal thrusts.

Continue uninterrupted until advanced life support is available.

CALL-FOR-HELP NUMBER: _____

*Older children are treated in same manner as adults.

When Breathing Stops

1 Check for Unresponsiveness

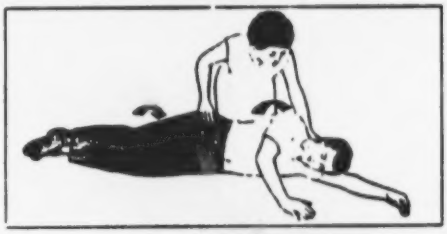
Tap or gently shake victim. Shout, "Are you O.K.?"

2 Shout, "Help!"

Get attention of people who can phone for help

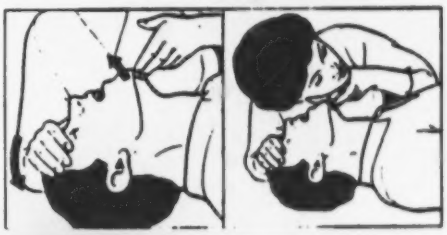
3 Position the Victim on His or Her Back

Roll the victim toward you by pulling slowly and evenly from the victim's hip and shoulder.



4 Open the Airway

Tilt head back and lift chin with fingers under bony part of jaw.



5 Check for Breathlessness

Look, listen, and feel for breathing for 3 to 5 seconds.

6 Give Two Full Breaths

Keep head tilted back. Pinch nose. Seal your lips tightly around the victim's mouth. Give 2 full breaths for 1 to 1½ seconds each.

7 Check for Pulse at the Side of the Neck

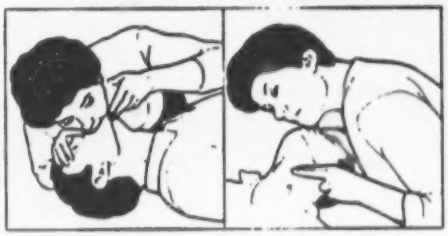
Keep head tilted back. Feel for carotid pulse for 5 to 10 seconds.

8 Phone EMS System for Help

Send someone to call an ambulance. Send 2 people if possible. Give location of emergency and condition of victim.

9 Begin Rescue Breathing

Keep head tilted back. Pinch nose. Give 1 breath every 5 seconds. Look, listen, and feel for breathing between breaths.



10 Recheck Pulse Every Minute

Keep head tilted back. Feel for carotid pulse for 5 to 10 seconds. If victim has pulse but is not breathing, continue rescue breathing.

Cardiopulmonary Resuscitation (CPR)

WE'RE FIGHTING FOR YOUR LIFE

American Heart Association

Place victim flat on his/her back on a hard surface.

1

If unconscious, open airway.

Head-tilt/chin-lift.

2

If not breathing, begin rescue breathing.

Give 2 full breaths. If airway is blocked,
reposition head and try again to give breaths.
If still blocked,
perform abdominal thrusts (Heimlich maneuver).

3

Check carotid pulse.

4

If there is no pulse, begin chest compressions.

Depress sternum 1½ to 2 inches.
Perform 15 compressions (rate: 80–100 per minute)
to every 2 full breaths.

Continue uninterrupted until advanced life support is available.

Help the Victim

1. **Rescue the Victim** from life-threatening danger, if necessary.

2. **Send Someone** to seek medical help, if the injury or illness is serious.

3. **Restore or Maintain Breathing and Heartbeat** using mouth-to-mouth resuscitation or CPR.

4. **Control Heavy Bleeding** by applying a clean compress and firm, direct pressure to the wound.

5. **Treat Poisoning** as directed by the Poison Control Center. Save any container and try to identify the poison, before calling the Center.

6. **Prevent Shock** by helping the victim to lie down and by maintaining body temperature.

7. **Examine the Victim** for other injuries.

8. **Seek Medical Help.** Call 911, if not done previously. Arrange follow-up medical care.

9. **Keep Checking** the victim's breathing and pulse. Don't leave until medical help arrives.

Get Emergency Medical Help Fast

While one person administers first aid or CPR to the victim, another must seek medical help.

Dial 911 or the emergency number for your area. Be ready to answer questions and provide important information:

Location of the Emergency, including cross streets, floor and room numbers, and the phone number from which you are calling.

What Happened? What kind of accident, injury, or illness occurred?

How Many People Need Help? Is anyone bleeding or unconscious? What first aid has been administered?

Don't Hang Up First! Be sure you have provided all necessary information.

Training in first aid and CPR can save a life. Learn it BEFORE you need it by contacting your Red Cross chapter.

FIRSTAID

YEARS

1985 by The American National Red Cross

ARC 247
May 198

PRECAUTIONARY GUIDELINES REGARDING BLOOD SPILLS/BODY FLUIDS

ATTENTION: Classroom teachers, physical education teachers, coaches, special education teachers, teacher assistants, school secretaries, vocational education teachers, administrators

DEFINITIONS:

Blood Spills: Blood from nose, mouth or skin lacerations.

Body Fluids: Includes blood spills, menstrual blood; as well as urine, feces, vomitus, diarrhea, mucous, and saliva (due to possible blood traces).

Gloves: Latex or vinyl gloves. Due to quality controls, **ONLY** American made products should be used.

Solutions to kill virus: Commercially prepared germicidal disinfectants are effective, but may be cost prohibitive.

(Prepare or purchase in small quantities.) Commercially prepared, yet economical, disinfectants include:

- Isopropyl alcohol with alcohol content of **40% to 70%** (surfaces only), or
- 3% Hydrogen peroxide (**skin** or surfaces).

Individually prepared solution of one part chlorine bleach to 10 parts water, 1:10 ratio (surfaces only).

Do not place solutions directly on body orifices. Avoid contact with eyes.
Store all chemicals out of reach of students.

TO CLEAN BLOOD SPILLS: (Blood from nose, mouth, or skin lacerations)

1. Put on gloves.
2. Immerse paper towel, cotton ball, gauze, or cloth, in 3% hydrogen peroxide.
3. Proceed to clean blood spill with the solution soaked material.
4. Place soiled materials in a plastic bag for disposal.
5. Remove gloves; include with soiled materials, and discard.
6. Wash hands for 15 seconds with soap and water, or
7. Rinse hands in 3% hydrogen peroxide.
8. Dry hands with a paper towel.

Hints:

1. Prepare a clean-up cloth (wash cloth or disposable wipe) in advance by dipping material in 3% hydrogen peroxide, wring out excess, and place in a sealable, plastic bag. Limit one cloth per bag. **Good for one day.**

2. Have a "clean-up" plastic bag in your desk, or pocket for recess or duty, along with your latex gloves. **Gloves cannot be reused.**

3. **P. E. teachers, Coaches, and Trainers need several bags ready for use in classes, athletic events, and team practices.**

178

TO CLEAN SURFACES: (Table, floor, desk, etc.)

1. Put on gloves.
2. Dip item used for cleaning in selected solution of alcohol, peroxide, or bleach water.
3. Wipe surface with solution.
4. Let surface air dry 3-5 minutes.
5. Discard paper products and gloves by bagging separately from other disposable materials
   -OR-
6. Place cloth or mop in washer and wash separately in hot water and detergent. Discard gloves and wash hands properly.

Hint: Have selected solution in a reusable spray container. Chlorine bleach solution must be replaced each week.

TO CLEAN BODY FLUIDS FROM A CHILD:
(Example: diaper, menstrual pad, skin. Do not use solutions on body orifices.)

1. Put on gloves.
2. Clean the child using a disposable wipe.
3. Place soiled materials in separate plastic bag for disposal.
4. Remove gloves; include with soiled materials, and discard.
5. Wash hands for 15 seconds with soap and water, or
6. Rinse hands in 3% hydrogen peroxide.
7. Dry hands with a paper towel.

It is recommended that disposable mouth pieces and/or face shields be placed with first-aid kits for use in mouth-to-mouth resuscitation or CPR.

These standard precautions, irrespective of AIDS and the HIV Virus, are **good health practices** that protect against a variety of infections (e.g. hepatitis A & B, mononucleosis, meningitis, encephalitis and other contagious diseases).

Questions and clarificationshould be directed to 1-800-342-AIDS.

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